VOLUME 44
NUMBER 8
MONTREAL
AUGUST
1948

CAMPUS CONVENTION

THE LAW AND HOSPITALS
N.V. BUCHANAN, K.C.

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Between Ourselves

The June issue of the *Journal* carried most of the reports of the previous biennium. We hope that you who were unable to be present in Sackville read them carefully, too. This month we have tried to paint a word picture of the whole series of events of the convention for you. This, in addition to the eye-witness accounts which your delegates will bring back to you, will set the stage for the various addresses which we shall be publishing in the September issue. The concluding reports from the convention and the summary of the findings of the Workshops will be available in our October number. We would welcome your comments on this distribution of the convention materials over a period of several months. Many nurses have told us that they were glad to have the reports before going to the convention. As was explained in that issue, this publication of reports before they are given rather than afterwards is a new departure. We would value your opinions in regard to this whole matter as an aid in determining what the policy shall be in 1950 and in succeeding years. Please write to us this fall and tell us what your reaction is.

We are all familiar with the popular opinion that tumors and, more specifically, cancer, are in some way linked with trauma. In discussing the validity of this conception, **Dr. William Boyd** states: "We can observe that one thing invariably follows another, but that is no proof of causality, for night follows day, but the two are not causally connected." Read Dr. Boyd's article carefully.

As children, the LAW to us meant the friendly policeman at the street corner who held up the traffic with a magnificent wave of his hand. As we grew older, the law acquired new and varied significance for us. It became a vast body of information known only to lawyers, magistrates, and judges. We learned something of its relevance to nurses, to the care of our patients, to hospitals in general, through our lectures as students. But there remains a general vagueness as to when the nurse or the hospital in which she is working may be sued for such a thing as negligence. **Nelles V. Buchanan, K.C.,** interpreted many of these problems for the hospital administrators of Alberta at an Institute. We are privileged to present his address.

August is usually the beginning of the infantile paralysis season. Most of the provincial and local departments of health have plans made well in advance for coping with current outbreaks. The outline which **Dorothy Hopkins** has given us of the Saskatchewan program presents a picture of a workable pattern.

We have long stressed the value of active health education programs for the school children. Community interest also is sought in developing projects for the enlightenment of the public in such aspects of health education as the pasteurization of milk, adequate nutrition, immunization programs, etc. Industry affords an excellent medium through which the nurse, who is awake to the opportunities, can carry on a broad program of health education with the employees for whose health care she is responsible. **Mary Rowles** has given us many illustrations in her thoughtful article of how it can be done.

It is several months since we told you how the *Journal's* circulation was faring. Some of the provinces have slipped considerably from their previous levels as the following figures indicate: *Alberta*, 673; *British Columbia*, 1,190; *Manitoba*, 544; *New Brunswick*, 469; *Nova Scotia*, 543; *Ontario*, 3,433; *Prince Edward Island*, 87; *Quebec*, 1,000; *Saskatchewan*, 1,140.

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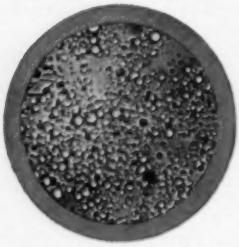

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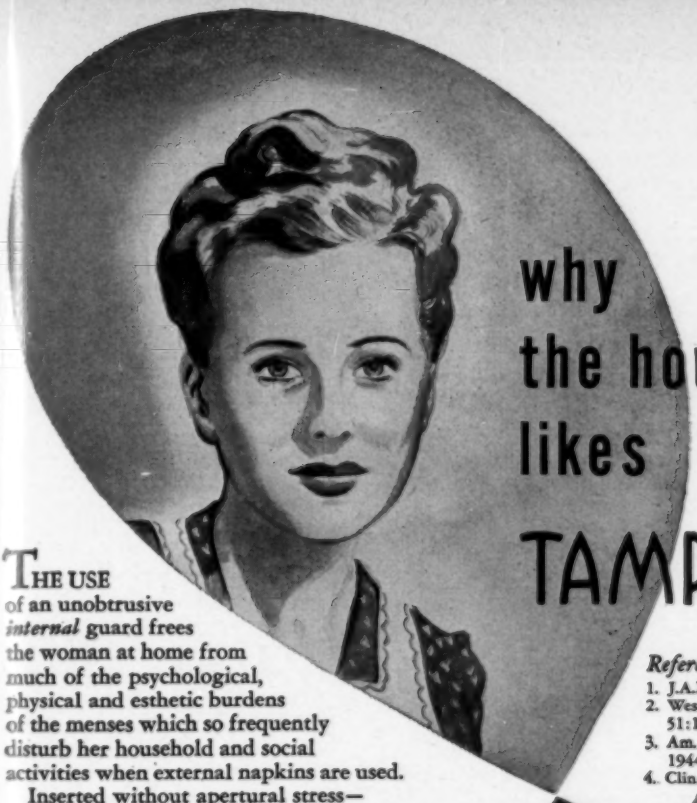

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References:

1. J.A.M.A., 128:490, 1945.
2. West. J. Surg. Obst. & Gyn., 51:150, 1943.
3. Am. J. Obst. & Gyn., 48:510, 1944.
4. Clin. Med. & Surg., 46:327, 1939.

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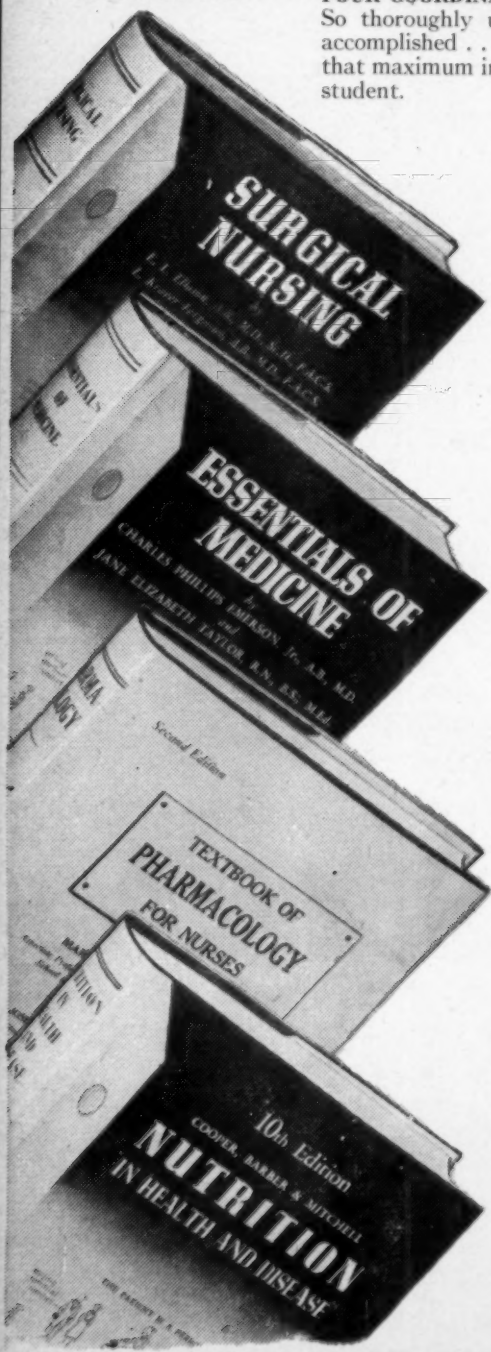

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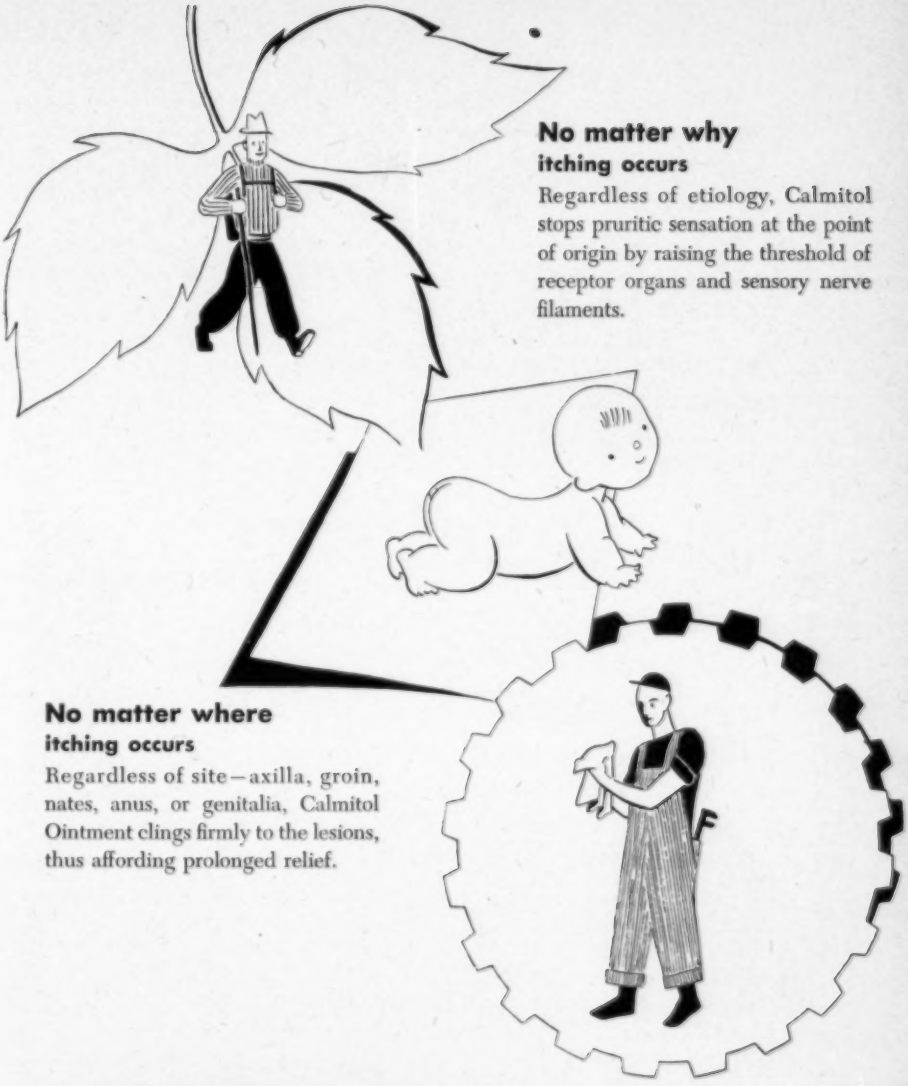

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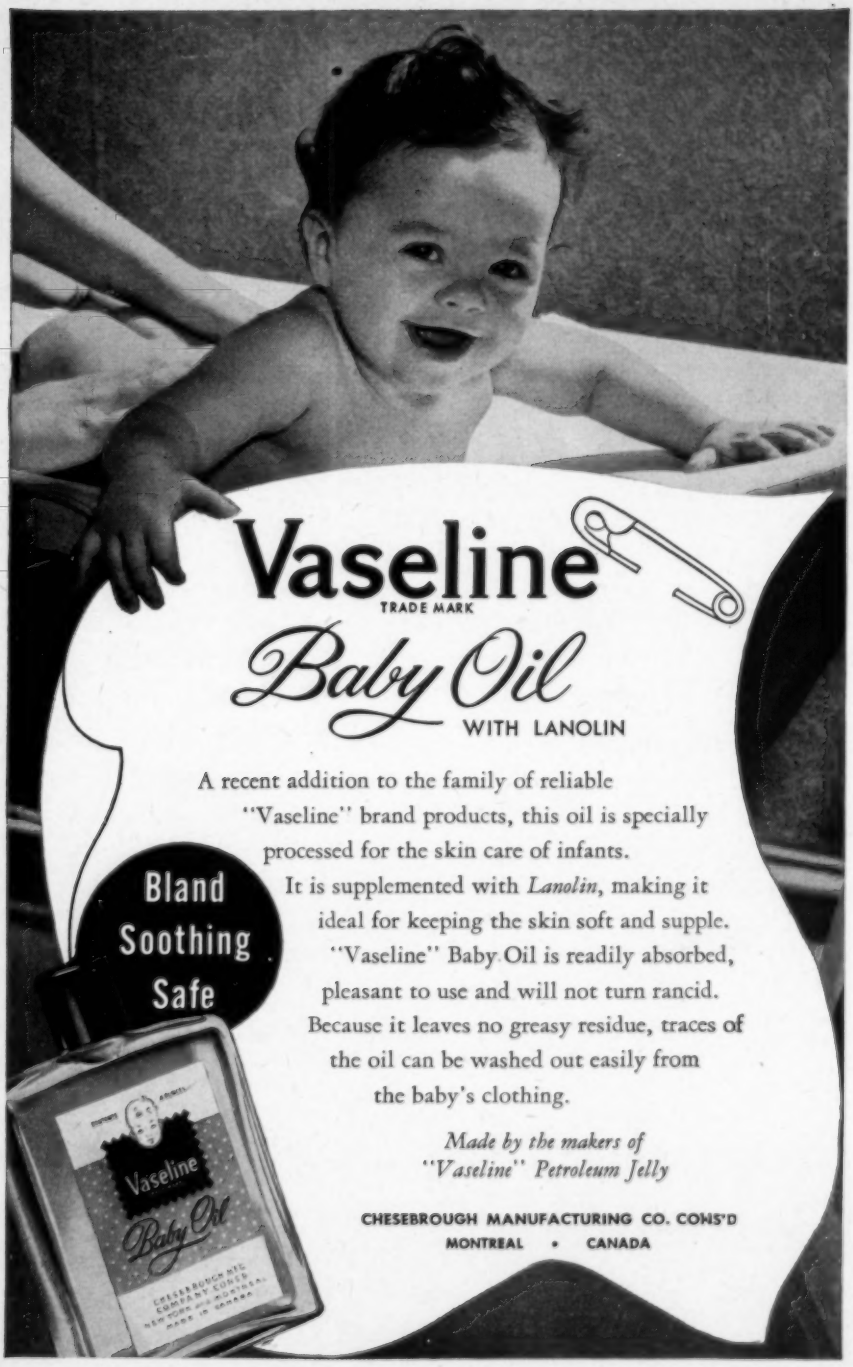
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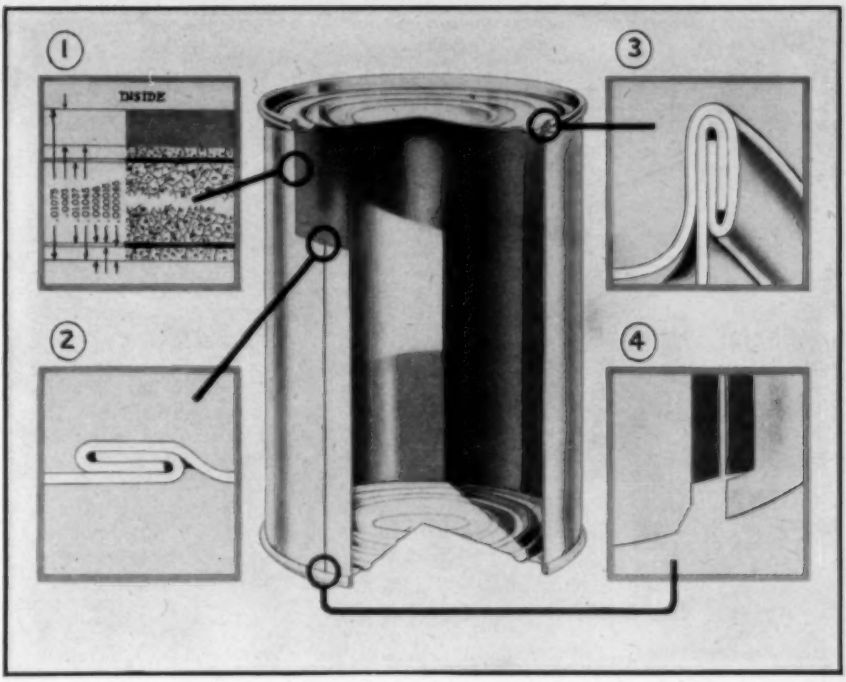

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-FOUR *NUMBER EIGHT*

MONTREAL, AUGUST, 1948

Campus Convention

THERE have been twenty-four national conventions so far in the history of the Canadian Nurses' Association but it is doubtful if there has ever before been one where the members had quite so many and such excellent opportunities to become well acquainted with one another. For five days, between six and seven hundred nurses swarmed the corridors of the residences at Mount Allison University in Sackville. They scattered over the campus in small groups, in streaming lines, in chatting throngs. The warnings of possible showers had prompted most to add rubbers and umbrellas to their baggage. Fortunately, the weather held fair despite frequent lowering clouds and overcast skies.

Various adjectives have been heard as descriptive of this convention. It was "unique," "friendly," "an austerity gathering." Certainly, the setting was very different from the customary hotel lobbies. A summer semester was in session at the same time, yet the University made such excellent adjustments in its schedules that it is doubtful if many of the nurses were even aware that classes were being held. The large numbers of nurses were comfortably housed in Trueman House, and in Allison Hall, while the Academy provided living accommodation for the religious sisters. Each of the three residences had cafeterias where delicious, well-planned meals were expeditiously served to the hungry throng. Some blamed their appetites on the sea air; others thought it was the absence of tension; the rest didn't bother to give a reason! Even the fact that they were in the dining-room before 8:00 a.m., *or else*, was accepted cheerfully. Taking turns

Gertrude Hall at the Registration Desk.

Representatives of many of the Communities of Sisterhoods were present.

under the showers provided adventure too, for you never knew who was coming along with an offer to scrub your back! The spirit of good fellowship and co-operation which pervaded the whole convention more than compensated for the minor inconveniences which cropped up occasionally.

The most conspicuous result of the regular meal periods was that the members were on hand for each session promptly and punctually. The auspicious opening was on Monday, June 28. The Lieutenant Governor of New Brunswick, the Hon. D. L. MacLaren, P.C., travelled up from Saint John

Dr. Flemington welcomes the nurses.

to bring us greetings. Mayor Beal, who was inadvertently introduced as "Mr. Sackville," assured us of the welcome of his townsfolk. Dr. W. T. Ross Flemington, president of Mount Allison University, was brash enough to claim that all of the finest people in Canada had ancestors from the Maritimes. He related that this University traced its history back to 1854 — the year Florence Nightingale led her heroic band of nurses to the Crimea.

One of the most delightful guests at the convention was Miss Janet Geister, first vice-president of the American Nurses' Association. In bringing greetings from our colleagues to the South, chubby Miss Geister stated, with her friendly chuckle, that "they couldn't send a lot of nurses so they sent a lot of nurse." As the

E. Flanagan, B. Pullen, J. Geister
B. Emerson, N. Gorgas.

laughter died down, she continued, "I don't like going out among strangers, but I haven't met any yet!" Miss Geister will long be remembered by the nurses who were privileged to chat with her and especially by those upon whom she bestowed her good luck coins — her "rubbin' money."

Numerous other celebrated person-

The Student Nurses' Workshop.

ages, who had assembled to participate in the workshops, added greatly to the enjoyment and interest of the convention. Mrs. G. A. Bennett, Chief Nursing Officer with the British Ministry of Labor, braved the trials of air-sickness and delays to join us. Mrs. Bennett brought greetings from the Royal College of Nursing and on their behalf thanked the nurses of Canada for the thousands upon thousands of parcels of food and sorely needed supplies despatched to Britain during and since the war. A special word of appreciation was given for the generous gifts of furnishings for the Rest-Breaks Homes.

Regretfully, Miss Lucile Petry had to cancel her participation in the program to represent the nurses of the United States at the first meeting in Geneva of the World Health Organization. Her place was ably taken, with only a week's notice, by Miss Ida MacDonald, co-ordinator of rural nursing education in the state of New York. Miss MacDonald was delighted to have the opportunity to visit the Maritimes as her parents were former Nova Scotians from Antigonish.

Another interesting and worthwhile development of the convention was the large registration of student nurses. Every province but Alberta was represented. Because of the surprisingly large number — nearly fifty — a special workshop was arranged for this group developing the theme

The Head Table at Business Sessions.

Ethel Johns being greeted by Dr. Flemington.

"Growing into Professional Responsibilities." The interest and enthusiasm displayed by this youthful aggregation lent a bright note to the assembly. It is to be hoped that future conventions will see even larger numbers of these, the coming members of the C.N.A., being introduced to the activities of their chosen profession at first hand.

The outstanding occasion of the opening day was the special convocation held by Mount Allison University for the presentation of Miss Ethel Johns for the degree of Doctor of Laws (*honoris causa*). Resplendent in the beautiful robes which had been presented to her by her own alumnae association, the Winnipeg General Hospital group, Miss Johns received the scarlet and blue hood symbolic of her doctorate. The convocation address will be published next month. The long line of well-wishers who stood outside Allison Hall, awaiting their turn in the receiving line, fell

Miss Margaret Murdoch pouring tea at the N.B.A.R.N. reception.

Lining up for the bus trip. *Staff Photo*

easy prey to the ever-present mosquitoes. The New Brunswick Association of Registered Nurses were hostesses at the reception.

Following the business sessions on Tuesday, various social events occurred. The Nursing Sisters' Association had jovial Dr. Flemington as guest speaker at their banquet. The president, Miss Rae Chittick, entertained the workshop consultants and other guests at dinner at Frosty Hollow Inn. Busloads of the members took advantage of the long hours of twilight to see some of the beauty spots of New Brunswick. Despite the fact that the last loads did not return until after 2:00 a.m. none of the tourers were late for workshops, or even for breakfast.

Wednesday being a very warm day, steady streams of nurses partook of "cokes" in the exhibit hall or had re-

Workshop Consultants

Back row: E. HOWARD, E. MCDOWELL, L. DORAIS, M. TRENHOLME, N. GORGAS.
Front row: H. SNEDDEN, M. SALTER, B. BENNETT, M. NASH.

Tea in the Lippincott Lounge.

DR. E. P. SCARLETT.

freshing cups of tea or coffee in the Lippincott Lounge. The "Universities Luncheon" at noon was well patronized though seating accommodation was not large enough to provide for all. The formal banquet at seven was also an overflowing affair. The nurses were divided as holders of pink and green tickets between Trueman House and Allison Hall. It was a joy to have all of the religious sisters participate with the rest of the members.

The Mary Agnes Snively Memorial Lecture was delivered by Dr. Earl P. Scarlett, the very good friend of the nursing profession from Calgary. Even in Charles Fawcett Hall, where all of the general sessions were held, the mosquitoes were pests. In spite of this diversion and the warm evening, the large assembly listened enthralled as Dr. Scarlett wove the magic of words into his splendid address "The Ram's Horn." In addition to publishing this memorial lecture in the September issue, it will be available later in tastefully bound reprints through the Canadian Nurses' Association.

H. MCARTHUR, SR. D. CLERMONT, B. KEY.

National Office Staff, Victorian Order of Nurses.

A view of the banquetters.

Head table—Trueman House.

And so the last day of this memorable convention dawned. True, it was Dominion Day and the national holiday. But to the nurses it meant the wind-up of business and no sessions were skipped. First, the voting delegates streamed out to cast their ballots before the workshops started. Then, like school girls, they hurried to their appointed classrooms for their final deliberations. The Registrars' Luncheon came at noon. After the closing session, the members who were not dashing for train or bus connections were entertained at tea by Mayor and Mrs. Beal. Someone dropped a very pretty bracelet at this tea. If not already claimed, the owner may write to *Mrs. Robert MacNaughton, 164 Portledge Ave., Moncton, N.B.*

This story would be incomplete without a word of sincere praise and appreciation to amiable Mrs. Mac-

Head table—Allison Hall.

Naughton and her indefatigable Arrangements Committee. Equally emphatic commendation goes to Mr. C. D. MacDonald, the business manager at Mount Allison University, and his corps of stalwart lads — students at the University — who served as bus-boys in the cafeteria, as guides, as assistants. Early and late they were on the job. Our grateful thanks to all of them.

Remembering our difficulties in securing suitable pictures at previous conventions, we employed the services of a photographer who took all of the illustrations used herewith. Any nurse who desires to secure copies of any of these may order them from *The Pridham Studios, Amherst, N.S.* The charge is sixty cents each. In ordering, use the caption beneath the picture to identify the selections desired.

There was a distinctly western flavor in the results of the election of the new slate of officers. They were: President, Ethel Cryderman, Toronto; first vice-president, Evelyn Mallory, Vancouver; second vice-president, Marion Myers, Saint John; third vice-president, Lyle Creelman, Toronto. Chairmen of special interest groups: Institutional Nursing, Elinor Palliser, Vancouver; Private Duty Nursing, Barbara Key, Hamilton; Public Health Nursing, Trenna Hunter, Vancouver. Nursing Sisterhoods: Maritimes, Sister Mary Beatrice, Glace Bay; Quebec, Sister Denise Lefebvre, Montreal; Ontario, Sister St. Albert, Toronto; Prairies, Sister Mary Irene, Prince Albert; British Columbia, Sister Mary Claire, Victoria.

Ethel Cryderman, President

JULY 1ST, Dominion Day, usually a day of celebration with Canadians, saw the nurses of Canada terminating their twenty-fourth biennial convention. The highlight of the last afternoon's business was the installation of the new president, Ethel Mildred Cryderman.

Miss Cryderman is well known in her native province of Ontario where she has long been very active in the affairs of the Registered Nurses' Association. Her name has been familiar to the nurses in other parts of Canada during the past four years when she has been, successively, second vice- and first vice-president. Now, as she assumes the heavy tasks as president of this nationwide organization, all nurses will be interested to learn more about Ethel Cryderman — the woman, the executive, the leader.

Walkerton, a small town in Bruce County, Ontario, was her birth-place. Five generations ago, her ancestors, United Empire Loyalists, came to Canada. Miss Cryderman reflects this long residence in her great affection for her native land.

After receiving her preliminary education in Walkerton, Miss Cryderman enrolled as a student in the school of nursing of the Toronto General Hospital. Following graduation in 1916, she engaged in private duty nursing for a few months, then enlisted with the Canadian Army Medical Corps and served until 1919 as a nursing sister. She received mention in dispatches in 1918.

Following her discharge from the armed services, Miss Cryderman qualified herself for the aspect of nursing to which she has devoted herself. She received her certificate in public health nursing from the University of Toronto and launched upon her civilian nursing career. It has carried her far! First, three years as staff nurse with the Toronto Department of Public Health. Inherent-

ly ambitious and capable, her qualities of leadership soon asserted themselves. In 1925, after courses in midwifery at Radcliffe Infirmary, Oxford, Eng., and in mothercraft in London, she became a district supervisor with the Toronto Department. Four years later, she joined the Victorian Order of Nurses for Canada as a national supervisor. In 1934, she was appointed to her present position as director of the Toronto branch of the Victorian Order of Nurses.

Miss Cryderman's training in mothercraft and midwifery proved of great assistance in the expansion of the maternity welfare program of the V.O.N. With the assistance of a nutritionist, she gave leadership to several maternity institutes which were carried on very successfully in various parts of Canada.

The world has need for people who can think objectively, reach sound decisions, and get things done. Miss Cryderman has given abundant proof that she possesses these qualities. She listens courteously and quietly to discussion. With a few well-worded questions she digs down under to the core of a problem, then suggests possible solutions. She is eager and energetic in securing the co-operation and support of others — be they nurses or laymen — for a project that is dear to her heart. Always dignified, poised, and unruffled, Miss Cryderman will lead the "parliament" of the Canadian Nurses' Association actively and with assurance. She makes it her business to know what is going on in every aspect of the work.

There is another side of Miss Cryderman which is perhaps less well known but is equally typical. One

ETHEL CRYDERMAN

of her outstanding characteristics is her thoughtfulness for people. A pot of her own home-made jam for this one who is sick — a box of candy or a book to help a shut-in to while away weary hours. Friendship she gives slowly but, when given, it is cherished.

Vacation jaunts have frequently taken the form of paddling or walking tours. Miss Cryderman loves the mountains and has done her graduation climb. A good deal of her make-up can be tied in with her love of mountains — the joy of struggle, the satisfaction of achievement. She is very good company on such an outing, taking her share in the cooking, camp-making, etc. She loves to be active. For a quieter period, Miss Cryderman likes to have someone read aloud a stimulating book and then argue about it.

This, then, is our new president. She will not fail us. We, the nurses of Canada, must not fail her. Every one of us must accept our share of responsibility for the accomplishments of the Canadian Nurses' Association during this new biennial period.

The Spice of Life

Doctors say parents should never force a child to eat. To insist upon a child eating something he obviously dislikes is a sure way of provoking an obstinate feeding problem. To force such a child to eat against his will is inviting trouble.

Child training experts point out that children don't always want the same amount of food every day, nor do they like monotony in their diet. Parents will find the child's feeding time is a smoother, happier event if they vary the ingredients of the child's diet and introduce new methods of food preparation.

The Relation of Trauma to Cancer

WILLIAM BOYD, M.D., M.R.C.P. (EDIN.), F.R.C.P. (LONDON), F.R.S.(C.)

WE ARE ALL familiar with the old saying, doctors differ. Anyone connected with Workmen's Compensation Boards knows that there is no subject on which they differ more widely and furiously than the causal relationship of trauma to tumors. This is inevitable for two reasons: first, little is known about the cause of cancer in man, so that there is plenty of scope for the imagination; second, the problem is a purely scientific one, and doctors are, fortunately, not pure scientists.

I have said that the matter pertains to pure science, which fundamentally is philosophy. For it is merely one facet of the great subject of causality, which is a purely philosophic concept. In the philosophic realm nothing is more difficult than the *proof* that one thing is the cause of another. We can observe that one thing invariably follows another, but that is no proof of causality, for night follows day, but the two are not causally connected.

Moreover, a superficial or common sense view of the matter may be misleading. The student of causality might be apt to think that the prone position of an intoxicated person was due solely to the effects of alcohol, but deeper reflection would at once make it clear that the all-important factor is the force of gravity. This simple example illustrates one of the most profound truths of causality, namely, that multiple causal factors must be sought, and that the matter is seldom as simple as might at first appear.

In the production of disease, exciting agents seldom act alone. The common sense viewpoint indicates that the causal agents of tuberculosis and diphtheria are the tubercle and diphtheria bacilli. But both of these organisms are often present in persons who never develop the clinical features of these diseases. To complicate the matter still further, it is impossible to demonstrate the Spirocheta pallida in a syphilitic gumma, and yet we know from indirect evidence that this organism is responsible for the lesion. These examples are given, not with the object of adding confusion to an already confused subject, but to demonstrate the great difficulty and complexity of the subject of causality quite apart from either trauma or tumors.

Those who have studied the special monographs and articles devoted to the relation of trauma to tumors must have been struck by the number of loose statements of a kind that would make a physicist blush if he caught himself using one of them. Thus "a malignant tumor may follow a single trauma." Of course it may, as it might follow a trip to the country or a birthday party. The sequence of events proves nothing. As Moritz remarks in his splendid monograph on "The Pathology of Trauma," if coincidence is to be accepted as a cause, alopecia and hemorrhoids may be shown to be due to trauma. "Studies in this field are as meagre as the statistical contributions are superabundant," is one of the most pregnant sentences in Ewing's discussion of the subject. Indeed much of the evidence may be described as anecdotal. Perhaps the most glaring example of a dogmatic statement, both meaningless and without foundation, is that of a German writer who declares that an important immediate cause of cancer of the lung is severe trauma which "does not produce laceration of the pulmonary tissue but only molecular disturbances of an unknown character." That, of course, is just scientific gibberish.

The possibility of coincidence must always be kept in the foreground. This becomes more evident if our statistical material illustrates cancer among injured persons rather than injury among cancer patients. Thus,

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the New York State Compensation Bureau encountered 37 cases of cancer among 26,000 injured persons. Since this is the normal incidence of cancer in the general population it is at once evident that these figures are of no statistical significance and merely indicate coincidence. About 25,000 persons are injured every day in the United States. As at 40 years of age, 400 persons per 100,000 are developing malignant tumors, it is not surprising that occasionally cancer should develop in the region of the injury. Even the long arm of coincidence may fail to bring injury and cancer together. It is a remarkable fact that cancer never seems to develop at the site of an operation wound or a fracture; certainly it is not a hazard which either the surgeon or the patient needs to fear. Nor am I familiar with a single instance of cancer developing in any of the hundreds of thousands of war wounds. It is perhaps (or perhaps not) even more remarkable that when cancer does develop at the site of trauma, that trauma happens nearly always to be occupational in character. Moritz, indeed, remarks that the chief reason why any scientific interest in the subject still exists is the great number of yearly claims for compensation.

Any medical problem can be attacked in one of two ways, either by the experimental method or by clinical observation.

When in the experimental animal we seek to determine whether trauma in the sense of a single or repeated contusing or lacerating mechanical injury can produce cancer we receive a negative answer. It is easy to produce different forms of cancer by a bewildering variety of agents, but never by simple trauma, either single or repeated. This is true even for animals with a strong natural tendency to develop cancer. The experimental evidence in laboratory animals is, therefore, entirely against the theory that trauma can produce cancer.

Turning now to the evidence obtained from observations on man, we enter an entirely different field, filled with pitfalls, bristling with contradictions, and presenting data of so nebulous a character that to make downright and categorical statements may be unwise and unscientific. While it is true that we cannot prove that trauma causes cancer, it is equally true that we cannot prove that it does not do so in man. There is often a discrepancy between theory and practice. A doctor will agree with the general scientific evidence divorcing trauma from cancer, but he will shy away from committing himself to a statement on paper that the relationship is impossible in a given case. Moreover, we are dealing with the most mysterious of diseases and one for which no satisfactory explanation can be given. It is only human, therefore, for the doctor to murmur: "Seeing that we know so little about this whole business it is just possible that the injury to this very part might conceivably have something to do with the development of the tumor." Should he feel particularly sorry for the man or his wife, it is likely that the statement will be more emphatic.

Moreover, when we consider the matter from the viewpoint of general pathology there is no inherent impossibility in the suggestion that a single trauma can produce cancer. All injury is followed by the proliferation of cells as a result of the diffusion into the tissue spaces of growth-promoting chemical substances derived from the damaged cells. The step between such cellular proliferation and neoplasia may in some cases be a short one.

We must admit, then, that the possibility that a single injury may result in a malignant growth cannot be denied. The real question is, does it happen, and if so how often? The most widely, or I might say, wildly divergent answers are given to this question by writers of equal authority. Thus Meyerding, of the Mayo Clinic, says that "in more than 50 per cent of bone tumors there is a history of localized trauma, followed by rapid tumor formation." And again Henderson, from the same clinic: "Trauma is probably responsible for bone sarcomas in 52 per cent of the cases." On the other side, we have Adair with his

vast experience of various forms of tumors, who declares categorically that "every evidence in our medical experience withholds support from the trauma theory of cancer production." Ewing can be quoted in support of either side, which is perhaps a tribute to the balanced judgment of that great pathologist. We can at least venture the remark that trauma can certainly not be a common cause of cancer, otherwise cancer would be a very much commoner disease. It may also be noted that the extremities are the parts of the body most frequently injured, but they are rarely the site of primary tumors. The head, again, is much exposed to trauma, yet gliomas can practically never be traced to a head injury.

This last example brings up a point which to me appears to be one of paramount importance. Cancer must not be regarded as a single disease. Different forms of cancer and cancer in different organs must be considered separately. Hormonal imbalance is likely to be a causal factor in cancer of the breast but not in cancer of the lip. Some tumors, such as sarcoma of connective tissues or cancer of the skin, might be accepted as resulting from reparative efforts following injury, because such structures normally show the proliferation characteristic of healing when they are in part destroyed, whereas others, such as adenocarcinoma of the stomach or bowel, would be unacceptable. In other words, each case must be considered on its own merits, and this is particularly true of compensation cases.

If it can be shown, and shown conclusively, that a tumor has developed at the exact site of an injury after a reasonable time (whatever that may mean), and if it can be proved beyond reasonable doubt that no tumor was present before the injury, and particularly if the site is a rare one for that particular variety of tumor, and if on general pathological grounds it seems reasonable to believe that trauma might excite this variety of tumor in this particular form of tissue, then I do not feel that we are justified in invoking evidence from experimental animals to deny the possibility or even the likelihood that the trauma should be regarded as a causal factor in the production of the tumor. Which is a wordy way of saying "I vote yes."

Chronic irritation is a very different matter from trauma. It is generally agreed that the action of a long-continued irritant may lead to tissue changes resulting in malignancy. This, however, does not enter into the present discussion. Of course it occasionally happens that an injury will set up a long-continued infection and irritation, which may eventually result in cancer. In such cases, due consideration must be given to the altered set of circumstances.

The question sometimes arises as to whether an injury may not aggravate the growth of a tumor and thereby shorten life. I am loath to admit this possibility. Injury to a tumor is likely to lead to necrosis by interfering with the blood supply, and this would tend to retard rather than hasten growth. Countless biopsies and aspiration punctures have been performed on tumors without harmful results. They do not even increase the danger of metastases, although injudicious handling and, still more, massage may start tumor cells on an Odyssey through the blood stream and lymphatics with disastrous results.

It sometimes happens that trauma will serve to call the attention of the patient to a hitherto unnoticed and unsuspected tumor, and in this way will be a means of saving his life. Thus, in one of my cases, a breast cancer the size of a hen's egg, with retraction of the nipple, was discovered three weeks after a woman sustained a blow on the breast in the course of her occupation. To suggest a causal relationship in such a case is palpably absurd.

In the preparation of this paper I have analyzed all the cases of what were claimed to be traumatic tumors which have been submitted to me by the Workmen's Compensation Board during the past ten years. I find that in six of these I have expressed the opinion that trauma might be regarded as a causal factor. Several of these

were skin cancers which were treated successfully. One was a malignant melanoma in the nail bed of a thumb which had been severely crushed. One was a fibrosarcoma following a hematoma caused by a blow. One was a bone sarcoma developing at the exact site of injury in a case of Paget's disease. In one there was injury to the nose followed by longstanding infection and eventually carcinoma. Perhaps I have been unscientific and unduly lenient in my judgment in these cases. Each of us can only do our best according to the light which is in us.

I shall conclude with a quotation from Ewing embodying a truth which is so familiar that I shrink from voicing it. "The great difficulty," says our supreme authority on neoplasms, "is the unreliability of the statements of interested persons. Self-interest and imagination quite unconsciously enter into and color every statement."

The Law and Hospitals

NELLES V. BUCHANAN, K.C.

MEDICAL practitioners have long recognized the impossibility of one individual excelling in all branches of medicine or surgery. The lawyers in their spheres entertain the same idea. In that spirit this paper is confined to "*Elementary* Facts about the Law": its object is not so much to inform as to convince you — if you should lack conviction on the point — that the path of the hospital administrator may be cleared of many obstacles by recourse to "preventive law."

For our purposes, when we speak of "the law" we merely mean the general body of rules recognized and enforced by the state in the administration of justice and the maintenance of good order. The term "law" may be used in two senses — one abstract and the other concrete. In the abstract sense, we speak of the law of England, the law of libel, criminal law. In the concrete sense we say that Parliament has enacted a "law": we speak of the by-laws of a hospital. The concrete term is much narrower in its application than the abstract term.

In the mouths of lawyers the words "the law" are habitually used in the abstract sense. When they have the concrete idea in mind they speak of some particular species of law — Statutes, Acts of Parliament, Rules of Courts.

Four brief definitions will be useful in our discussions:

By *Criminal Law* we mean the law relating to offences considered injurious to the community as a whole; the object of Criminal Law is the punishment of the offender, and the punishment can be remitted only by the Crown.

Civil Law is now used as the name for that part of the law of a state not considered in Criminal Law. The object of Civil Law, broadly stated, is to adjust the rights of individuals.

Common Law, sometimes called the unwritten law, consists of the rules of law developed and evolved by the judges in the courts.

Statute Law, or written law, consists of express enactments by legislature or by parliament.

Divisions of subjects: I have arbitrarily selected the following three departments for treatment: (1) Negligence: Under what circumstances can a hospital be made liable in damages to (a) a patient; (b) visitors to the hospital; (c) an employee? (2) Statute Law and hospitals; (3) some administrative legal problems.

Mr. Buchanan is legal adviser to the Associated Hospitals of Alberta.

Negligence

Undoubtedly a question of gravest concern to the administrative officers, the medical staff, and the nursing staff is: under what circumstances can the hospital be ordered to pay damages for the negligent acts of any hospital employee or of the hospital in its corporate activities? An answer to this question calls for a brief explanation of that variety of injury or wrong known as a *Tort* within which group negligence falls.

A *Tort* is an act done by A to B whereby A without just cause or excuse has caused some form of harm to B. An action of Tort is a claim for money compensation in respect of damage so suffered. The variety of Torts are numerous: conversion of property, assault, defamation (libel when in permanent and visible form; slander when spoken or gestured), malicious prosecution and negligence — all these and many others.

What is the tort known as *negligence*? It is conduct which involves an unreasonably great risk of causing damage. It is the omission to do something which a reasonable man would do or doing something which a prudent and reasonable man would not do. Negligence indicates the breach of a duty and damage thereby suffered by the person to whom the duty was owing. There is no liability for negligence unless there is in the particular case a legal duty to take care and this duty must be one which is owed to the plaintiff himself and not merely to others. The law does not require the highest degree of care. The question always is whether the defendant attained to the standard of due care established by law. The care taken by a common and prudent man has always been the rule laid down: "the man who takes the magazines at home and in the evening pushes the lawn mower in his shirt sleeves." The burden of proving negligence is on the plaintiff who alleges it.

Contributory negligence: Harm is sometimes suffered by a plaintiff not solely through the negligence of the defendant but also through that of the plaintiff himself. Under our Contributory Negligence Act a judge is permitted at trial to assess the degree of negligence or the percentage of negligence of which the plaintiff and the defendant respectively are guilty.

The most effective fashion of learning to recognize actionable negligence in the conduct of a hospital is to examine cases from life. The following are a few among the hundreds that have appeared in various Canadian law reports within recent times:

The plaintiff is brought to the hospital by his family physician to be operated upon for a ruptured appendix. Operation successfully performed with duly qualified nurses in attendance. To combat shock following operation two rubber hot water bottles, placed inside flannelette bags, were filled by the matron with quite hot water and placed in the plaintiff's bed. The next morning it was discovered that the plaintiff's left leg had been severely burned. Supreme Court of Canada held that the proximate cause of the accident was, in the first place, the filling of the hot water bottle with water that was much too hot without any test of it; then the failure to test and see whether any adjustment was necessary. The failure to investigate was attributable to the nurse. Held that the obligation undertaken by the hospital was not merely to supply properly qualified nurses but to nurse the plaintiff. It was the negligence of the hospital in discharging that contractual obligation that caused the severe injury of which the plaintiff complained. Judgment for the plaintiff.

* * *

A plaintiff sues upon the ground that shortly after an operation, while under the influence of a sedative, but not yet asleep, she was permitted to roll out of bed and, secondly, that after a very serious and delicate operation and before the process of healing was complete, one of the nurses had attempted to replace a tube, tore the sutures, and thus destroyed all beneficial results of the operation. A supervisory nurse, without the advice or assistance of the patient's own physician and upon the suggestion of an interne, an employee of the hospital, re-inserted a tube which had partially come through the wound. Held by an Alberta Supreme Court judge that the fall out of bed was the result of lack of reasonable care on the part of the nursing staff, and that in respect of the attempt to replace the tube and tearing of the sutures there was lack of proper management and

control in the operation of the hospital, that there should have been immediate communication with the patient's doctor as soon as it was discovered the tube was slipping out, and that no nurse should have been permitted to tinker with the tube. Damages of $15,000 awarded to the patient.

* * *

The plaintiff was admitted to defendant hospital. Her condition diagnosed by her physician as sciatica; supervising nurse ordered to see that patient given diathermic treatment to relieve her pain. Treatment given by a nurse, a permanent member of the staff. Patient's physician had nothing to do with the actual treatment. Patient was burned. Court held the nurse was negligent, that she was the agent and servant of the hospital. Damages of $3,000 awarded by the Supreme Court of Canada.

* * *

A child was brought to hospital suffering from pneumonia and steam inhalation was ordered. Apparatus consisted of an ordinary tea kettle set on a chair with a short length of hose carrying steam from the kettle to the child's crib. Child placed in a crib fitted with a sheet as a canopy and steam introduced under the canopy by the hose. In some unaccountable way and without any proven negligence on the part of the hospital or its employees, the child was found severely scalded. Held that since evidence was that the apparatus, if operated with care, was satisfactory, there must have been absence of proper care. Damages awarded to parents of the child by Ontario Supreme Court judge.

* * *

Plaintiff entered hospital with cataract on each eye, but for removal of cataract on right eye only. Cataract of right eye successfully removed and patient was progressing favorably. During a noonday meal, while in the act of taking soup fed to her through a tube, something happened as to which the evidence was conflicting. Feeding patients was a routine matter with this nurse and she failed to concentrate. She denied that any soup spattered on to the plaintiff's face but remembered patting the plaintiff's face with a serviette. Overwhelming evidence that after the accident there were reddish patches on plaintiff's face below the mask. Upon re-examination surgeon found that a prolapse, or "protusion out," of plaintiff's eye had occurred. In final result plaintiff lost sight of eye. Evidence was that but for the prolapse plaintiff would have had good post-operative result in right eye. Judgment for $4,000 by Ontario High Court.

* * *

Infant plaintiff had been a diphtheria patient in defendant's hospital and had been discharged therefrom as cured and returned home. Found nine days later to be suffering from smallpox, the incubation period of which is ten to fourteen days. Damages were claimed from the defendant hospital upon the grounds that smallpox had been contracted owing to its negligence, the negligence charge being: the placing of smallpox patients next to the plaintiff and the attendance upon the patient by nurses who also attended the smallpox patients. Technique adopted by the hospital was known as the "sterilization method." The hospital was prepared to admit that smallpox had been contracted by virtue of what is termed "cross infection" while she was in a room on the third floor of the hospital and while she was attended to by nurses assigned without discrimination to the patients on that floor. This technique had the approval of all the senior medical authorities in Vancouver and had been adopted after a deputation of both Vancouver city authorities and Vancouver General Hospital authorities toured the hospitals of the U.S. Held that a defendant charged with negligence can clear his feet if he shows that he has acted in accord with general and approved practice. Held by the Judicial Committee of the Privy Council that the only question to be decided was whether the plaintiff had succeeded in proving that the defendants were negligent in adopting the hospital technique in question and that, in view of the favorable opinion expressed by all the defendant's medical witnesses regarding the said technique, the absence of any contrary opinion except that of the plaintiff's own physician, and due also to the fact that the said technique was in accordance with the general, if not universal, practice in Canada and the U.S., the charge of negligence failed.

* * *

A local authority operating a hospital admitted a patient, taking possession of certain jewellery and a cigarette case which she had in her hand-bag. The hospital was unaware that the articles were of value, but shortly afterwards it received a letter from the patient's sister asking for confirmation of the contents of the patient's hand-bag and referring to diamonds. The hospital did not re-

ply. The articles were entered in a book and stored with hundreds of others in envelopes on the floor in a room which a burglar would have had no difficulty in breaking into. They were not put in a safe even after receipt of the letter and they disappeared, presumably being stolen. Held by a judge of the K. B. Division, England, that the hospital was not entitled to assume that the patient's property was of no value and that the hospital was negligent in not storing the property in a safe, particularly after the letter of warning.

* * *

A lady visiting a patient of the defendant hospital, stepped on a mat, slipped on a highly polished linoleum on the floor, fell, and was seriously injured. The polishing was for a good cause, namely for antiseptic purposes. The court held that the hospital authorities, being aware of the polish and of the probable movement of an unanchored mat when stepped upon, were guilty of negligence to the visitor in failing to remove the mat, or leaving it and failing to make it fast, and were held liable to the plaintiff.

* * *

A pupil dietitian was injured in an accident caused by the fall of a dumb-waiter used to carry food from the basement to the second floor. The dumb-waiter was raised and lowered by a rope operated by the student. The hoist fell, crushing her forearm. It is not clear whether the rope broke or became detached from the top of the car. No evidence of recent inspection of the rope. The pupil dietitian denied that she had been instructed in the use of the side door which she failed to employ. The superintendent's evidence was that she had instructed the plaintiff in the proper use of the hoist. Held that there was both negligence and contributory negligence, two-thirds by the defendant and one-third by the plaintiff.

* * *

In an action against a sanatorium for negligence in permitting a patient to escape and drown himself, evidence sustained during findings that the patient had suicidal tendencies and that the sanatorium authorities had or should have had knowledge thereof. (An American case).

* * *

In an action for injuries to a cripple, slipping and falling on a slick concrete walkway, sloping upwards towards entry to medical clinic building, to which he was going for eye examination, evidence of defendant's negligence in having a sloping walk along which the defendant must have known that people with defective limbs would walk, was held sufficient to support the jury's verdict for the plaintiff.

These illustrations indicate that after administrative officers of a hospital have made the best disposal at their command of staff, equipment, and all physical facilities, there remains the unknown and unpredictable human factor. Therefore, as neither you nor I can afford to drive a car around the first corner uninsured, so no hospital can afford to operate for one moment unless covered by adequate and comprehensive liability insurance. Incidentally, may I remind you of the wisdom of prompt notification to the insuring company of claims against your hospital and of the lack of wisdom of entering into anything savoring of negotiations with the claimant, once a claim has been made. That is forbidden by the terms of every policy.

Statute Law and Hospitals

On the statute books of the provinces there will be found a lengthy series of acts of peculiar significance to hospital administrators. One point should be emphasized: no government can afford to ignore suggestions as to new legislation and amendments to old, tendered to it by experts in the field in which the legislation operates. In Alberta, and this province is not likely to be peculiar in this regard, representations as to necessary and advisable amendments have been listened to sympathetically. When the Alberta Hospitals Act was being redrafted in 1937-38, the assistance of the Legislative Committee of the Hospitals Association was sought. Over a period of years any organized group of hospitals can bring about legislation and amendments to legislation, advantageous to hospitals. To illustrate: up to 1938 one could not be certain, in Alberta, of collecting a minor's account from a parent without proof of contract, actual or constructive, with the parent. An amendment in 1938 made the liability of parents

statutory. The reverse likewise is true, namely, that if organized hospitals sleep on their privileges, legislation of vital interest to them may be amended in such fashion as to prejudice and thwart the proper purposes of hospitals. To illustrate: Amendment to an exemption act made collection of hospital judgments against the ordinary citizen almost impossible. Only after enactment was this situation discovered and, upon representations to the Attorney General, certain amendments giving greater leeway to hospitals were eventually made.

A bit of Alberta legislation which does not appear to have been experimented with widely in Canada is the Hospitals Lien Act, of which American legislation was the model. This act gives to hospitals, upon proper notice to the parties concerned, a lien upon the damages recovered in actions by patients for damages against those occasioning the injury. In view of the extensive hospitalization of motor car victims and the extensive damage actions which result therefrom, these liens become of increasing value to hospitals.

Some Administrative Legal Problems

These are legion! There is a great variation between the problems arising in city hospitals and those in rural or outlying areas. The following are selected from among many:

Employer and employee — Master and servant:

(a) Note that a master is liable for any tort committed by his servant in the course of his employment but the servant, in committing the wrong, must have acted in the course of his employment — e.g., a hospital board is not responsible for a malicious criminal prosecution undertaken by its manager, but would be liable for a mistaken act of its porter in ejecting by force an unoffending visitor. If an office employee steals anything entrusted to him while acting in the course of his employment, the hospital board is liable: the employee did fraudulently what he was employed to do honestly and the employer answers for it.

(b) It should be noted that a hospital is entitled to receive notice of termination of employment by an employee in the same manner as the employee is entitled to notice by the hospital. In every case the notice must be "reasonable" having regard to the nature of the employment, the circumstances of hiring, the method of paying, the probability of ready re-employment. Two weeks or a month would meet the requirements with most hospital employees.

(c) May a hospital dismiss an employee without notice? Under certain circumstances only — e.g., in the event of wilful disobedience, grossly immoral conduct, habitual negligence, or a criminal offence.

Hospital and patient:

(a) *Patient records*, x-ray films — who owns them? It has generally been held that they belong to the hospital and not to the patient, unless by special agreement. They are of no value except to a trained interpreter.

(b) *Office practice:* If a patient marks a cheque "payment in full" when in fact the cheque does not cover the full account, is the hospital precluded from collecting the balance of the account if it cashes the cheque? The correct procedure is to advise the patient promptly on the date of deposit of the cheque that the cheque is being deposited but is not being accepted as in full, then proceed for the balance.

If a hospital has a judgment for an account, is it wise thereafter to accept a note or to enter into an agreement permitting payment by instalments? A new security or agreement taken after the recording of a judgment wipes out the judgment. If a new agreement is entered into in respect of a judgment, care should be taken to provide that in the event of default in complying with the terms of the new arrangement, the judgment shall again become effective.

Regarding threatening letters — note that to threaten criminal proceedings against anyone is in itself a criminal offence. This situation

might arise out of the giving of a N.S.F. cheque by a patient on discharge.

(c) *Consent to operations:* No surgical operation should be performed on an adult patient without his or her consent, if it is possible to obtain it. No operation, therefore, should be performed on a patient without the express consent of the patient in writing or, if he is not in a position to give such consent, of his nearest relative. The consent of the patient should be founded upon full knowledge of the nature and possible extent of the operation and the consequences which it may involve. Disregard of these rules will render the surgeon and hospital liable to an action for damages. In the case of a child, similar rules should be adopted except that, instead of the patient's consent, the consent of the parent or guardian should be obtained. No operation must be performed by the surgeon other than the one for which consent has been given.

To illustrate: The plaintiff, a master mariner, brought action for $10,000 damages against the defendant, a surgeon of high standing, claiming that the surgeon while performing an operation on the plaintiff for hernia, while the plaintiff was under the influence of an anesthetic, without the knowledge or consent of the plaintiff, removed an organ, the removal of which was not authorized. The plaintiff claimed that in removing the organ mentioned, the defendant committed an assault upon him. The defendant claimed that the removal of the additional organ was a necessary part of the operation for hernia and that the necessity for removing the organ could not have been reasonably ascertained by diagnosis before the operation and that consent to the further operation was implied by the plaintiff's request to cure the hernia. The defendant called as witnesses three eminent surgeons, all of whom agreed that if the additional organ had not been removed the man's health and possibly his life might have been in danger. The court held that when, during an operation, a practitioner forms an opinion that it is necessary, in order to save the patient's life, to remove some organ or limb, and accordingly removes the organ or limb, the practitioner cannot be charged with negligence for having taken that step, unless there is evidence that express instructions were given by the plaintiff that no organ or limb should be so removed and that the operation was performed negligently.

* * *

A young lady stepped on a nail which penetrated the third toe of her right foot and inflammation set in. The wound not having healed, the surgeon made an examination and advised that an operation was necessary to effect a cure and that the operation should be made by making an incision in the foot or toe so as to drain off any foreign matter that might be found therein. She consented to the operation upon the express condition that no bones should be removed. An anesthetic was administered and, in performing the operation, the sesamoid bone was removed. An action of assault and battery was commenced based upon the contention that removal of the bone was unauthorized. The verdict was rendered in her favor. It was stated that the condition did not constitute an emergency. (An American case).

More Soup

Campbell Soup Company Ltd., New Toronto, announce they are now supplying the restaurant, hotel trade, and hospitals with a new institutional size can of the famous Campbell's Soups containing forty-eight ounces. At present the new size can is packed in seven kinds: beef noodle, bean with bacon, beef, chicken with rice, chicken noodle, cream of mushroom, vegetable beef. Other kinds will be added from time to time.

This will now enable the chefs to serve hospital patients with the same famous Campbell's Soups that are served at home, both profitably and conveniently.

Poliomyelitis Clinics in Saskatchewan

DOROTHY M. HOPKINS

THE people of Saskatchewan are conscious that protection from poliomyelitis can be obtained by maintaining a preventive campaign for early discovery and treatment of persons suffering from poliomyelitis. It is understood that the population must be informed thoroughly regarding early symptoms of the disease and the steps to be taken when such symptoms occur. Public education has been increased through the doctors, nurses, the press, schools, clergy, radio, cinema, and the growing activities of women's organizations.

The problem of poliomyelitis, according to Kenny, lies in the fact that the muscles that are affected are in spasm. Pain and tenderness are caused by the spasm in the muscle and the result is that the muscle is shortened. It is not necessarily the whole muscle that is in spasm — it may be only a few fibres. The spasm is detected by the inability of the muscle to stretch to its fullest extent.

The terms "alienation" and "incoordination" are used frequently. In alienation there is a functional break between the brain and the muscle and the patient appears to have forgotten how to use this muscle. In other words, it becomes alienated from the brain control. There is also lack of co-ordination between the flexion of one group of muscles and the corresponding relaxation of their antagonistic group. One of the most striking things about polio from the diagnostic point of view is the high proportion of anomalies one encounters. Some cases will have limb paralysis with no neck or back stiffness, and vice versa.

The effectiveness of the Kenny Method is shown in the fact that following it there are few deformities. Although immediate treatment is essential many remarkable improvements have been made in cases of fairly long duration.

It is important to understand that the nature of polio may possibly be changing. "The nineteenth century virus was epitheliotropic, carried by adults, antibody-producing, and through recurrent asymptomatic episodes produced eventual immunity. The twentieth century virus is neurotropic, spread by children, and incapable of producing more than a temporary immunity."

In a province like Saskatchewan, where there are free treatment clinics, the patient is spared the worry of financing such an illness, which is an important feature in promoting recovery from the disease. In 1943, a Polio Clinic was organized in St. Paul's Hospital, Saskatoon. Treatment was designed to reduce disability and prevent the appearance of late deformities using the Kenny type of treatment. A public health nurse, specially trained in hot-packing and muscle re-education, inaugurated this service under the direction of a doctor who had special training in the Kenny technique. After discharge, a public health nurse visited the patients in their homes and made a written report, noting improvement, etc.

In 1947, expansion of clinic facilities for polio was made by the Saskatchewan Department of Public Health. In addition to the clinic at St. Paul's Hospital, about fifty beds were made available at the Regina General Hospital. The Saskatchewan Department of Public Health provided special equipment such as Munsingwear for the fomentations, a washing machine and wringer, as well as the services of health nurses from the city and provincial departments. A public health nurse, specially trained in hot-packing and muscle re-education, was in charge of this phase of treatment. The provincial health department contracted

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with orthopedic surgeons to provide free treatment for clinic patients, as well as out-patient service. A third and smaller treatment centre was established at the Moose Jaw General Hospital.

Completeness of records of examination could best be assured through the use of a printed form such as the questionnaire herewith. It has probably many shortcomings but it is an attempt to provide something reliable.

The public health nurse has been privileged to play a major role in the polio clinics in Saskatchewan in the actual treatment and follow-up of the patients.

Poliomyelitis Clinic Record

1. *Present history:*

Date of first symptoms.....19.... of onset of paralysis
Month Day
.....19.... of diagnosis.....19.... Onset:
Month Day Month Day

Fever (high, moderate, slight).....
Give degrees of temp. and dates if noted, otherwise duration.

.....Chills.....Pulse.....
Rate

Headache (severe, moderate, slight).....
Give date of onset and duration.

Dizziness.....Epistaxis.....

Constipation, Diarrhea.....
Give date of onset and duration.

Vomiting.....Sore Throat.....
Dates of frequency.

Pain.....
Character and distribution, date of onset and duration.

Pain on anterior flexion of.....Neck, Back.....

2. *Past illnesses:*

Was previous general health of patient: excellent, good, fair, poor?.....

Was patient: well nourished, active, robust?.....

What previous sickness, indisposition, or injury has patient had and when?.....

.....

Have patient's tonsils been removed?.....If so, when?.....

Has patient been associated with any paralyzed or abortive case?.....

If so, give.....
Full name of case and date and circumstances and place of association.

.....
If patient has been away from home, where and when.

3. *Family history:*

Names and ages of members of family (including guests, boarders, hired help, etc.): Status of family — rich, poor, medium?.....

Has anyone in household been sick within one month before or after this case?.....

.....

Give name, sex, age, date, and nature of each case.....

Has anyone in household been associated with any previous paralyzed or abortive case?.....

.....

If so, give name and address of case.....and.....

.....

Full name of associate, and date and circumstances of association.

4. *Social history:*

Have any infectious diseases, respiratory troubles been unusually prevalent in the community?

.....Are sanitary conditions of premises excellent, good, poor, bad?.....

Remarks

Has house sewer connections? cesspool? privy? Is privy flytight and sanitary?.....

.....

Remarks

In the house or on the premises are there lice? bedbugs? fleas? ticks? horse flies? house flies? biting house or stable flies? rats? cats? dogs? birds? other pets?.....

How far is it to the nearest stable from patient's house?.....

What animals or fowls are kept at stable or in vicinity?.....

Has there been any paralysis among animals or fowls in vicinity?.....

Weather conditions just prior to attack.....

Hot, mild, cold, wet, dry, dusty, otherwise unusual?

.....

Milk supply.....Pasteurized.....Raw.....

Name of dealer.

If patient went swimming or took cold plunge bath during 10 days prior to illness, give dates and places.....

Remarks.....

Note any circumstances which may relate to source and mode of infection.

.....

Give names of visitors to family and members of family visiting other communities with dates and places.

.....

5. *Examination:*

Tenderness.....Tremor, Twitching.....

Distribution, date of onset.

.....Retraction of head.....

Distribution, date of onset

Posture in bed.....Restlessness.....

Drowsiness.....Reflexes.....

Kernig, Babinski, Gordon.

.....

Pupil: dilated, contracted, unequal, reaction to light, paralysis.

Eruption.....Distribution of muscle weakness

Date, character.

at its worst.....

If possible, state sequence of paralytic symptoms.

Extent of paralysis remaining.....

Also note any deformity.

.....cc. of clear, cloudy, bloody spinal fluid flowing under.....

.....pressure on.....

date date date date

Showed upon laboratory tests.....

Effect of lumbar puncture on patient's condition was.....

.....

If serum was used note amount and effect.

Stiff or rigid neck..... Irritability.....

Muscle spasm..... Difficulty in swallowing.....

Difficulty in breathing.....

6. *Death:*

On.....19..... was due to.....
Month Day

I have had Polio

MAY HARROWER

EVER since I was old enough to know what was going on about me, I had heard of the damage done by the dread disease infantile paralysis, or poliomyelitis, the name by which I now know it. I had seen a few people maimed and crippled by its ravages, but apart from sympathizing with its victims, I never thought much about it. When I became ill and found my legs would not even hold my weight, the chance that I might have polio never entered my mind. In fact, all my thoughts were occupied with the continuous, indescribable, aching pains in my legs and back. My one wish was to get relief.

Our family doctor was vague in his diagnosis, mainly, I suppose, because he did not wish to alarm us. However, he wasted no time in sending me to the polio clinic in a nearby city. The public health nurse technician, who had gone off duty, came to examine me the moment I arrived.

I was placed on a bed which had plain boards between the mattress and springs and which was minus any kind of pillow. At that moment I felt rather mistreated. It seemed to me, when I was in such pain and discomfort, that a soft bed with my head propped up on pillows would add more to my comfort. But in reality, the purpose of the boards was to keep my back as straight as possible during the time my muscles were in spasm, and to keep it that way after the spasm had subsided and the muscles were resuming their normal position and shape. The only cover I had over me was one wool blanket which I noticed was not resting on my feet. I was told it was hung over a board, placed at right angles to the bed, in order to keep the weight off my muscles. I was not to move, but to relax completely.

After the public health nurse had examined me, my first treatment began. In a few days I learned that this was the Kenny treatment. It consisted of hot packs which were applied all over my body with the exception of my face and hands. The packs were made of 75 per cent wool and there were many pieces cut in different shapes to cover each set of muscles. The joints were left uncovered. For example, there was one triangular piece to cover the upper arm and shoulder muscles, which included deltoideus, coracobrachialis, biceps and triceps. They were applied as hot as I could stand them. The moist heat was held in each pack with two other separate covers — one oilskin and one dry blanket covering, pinned securely. This was the first real relief from pain that I had had. I had these

packs every day with the exception of some Sundays, until I came home five months later.

Then I had active and passive muscle re-education and stretching. After approximately the first week of my illness the nurse technician began my passive muscle re-education, which included complete relaxation. Have you ever tried to allow every muscle in your body to become limp? It was a most difficult thing for me to learn to do. To re-educate passively the muscles in a toe, for example, I relaxed and she moved the toe without any assistance or effort from me.

Then came active muscle re-education which was started a short while after the spasm was over. This took concentration. I moved a toe to the best of my ability and as I did so my whole thoughts were centred on the muscle involved. Learning the names of my muscles helped me to concentrate on each one as I tried to pull with it. In this way my muscles were slowly brought back to natural activity.

Stretching my muscles which were contracted was the only pain I had after the first weeks of spasm. Some of the muscles took many months of stretching to return to normal.

My morale, along with that of the other polio patients, was kept up wonderfully by moving pictures shown in the ward, parties on special occasions including a huge Christmas celebration, and cheerful encouragement from our attendants. After the painful part of polio had passed, I found I was enjoying myself.

Gradually my condition improved enabling me first to sit up, later to stand with support, and finally to walk a few steps. When I took those first difficult steps I knew that a near miracle had been performed and I could walk again. I owed my recovery to the effectiveness of the treatment and the way in which it was given, and to our family doctor for sending me to a polio clinic without delay.

When I was allowed to go home, I was given instructions to continue my exercises and long periods of rest on a hard bed. Now, over a year later, I have recovered and am looking forward to taking up a vocation very soon.

A few months following discharge the public health nurse who was in the clinic visited me to see me do my exercises, noted the improvement and made suggestions.

My family and I have lost our dread and fear of polio. We realize that this, too, can be conquered. I sincerely hope that in the future more and more doctors and nurses will be trained to administer this treatment and thus save many thousands from spending the rest of their lives in a wheel chair, as could have been my fate.

New Bulletin on Polio

A new bulletin, dealing with the problems of "Nursing for the Poliomyelitis Patient," has just been prepared and published by the **Joint Orthopedic Nursing Advisory Service** of the National Organization for Public Health Nursing and the National League of Nursing Education. Copies may be secured by writing to them at *1790 Broadway, New York City 19.*

This is a revision and compilation of material formerly found in several handbooks. It presents the most up-to-date instruction on the nursing care of poliomyelitis patients that is currently available.

If you can stand being always your own severest critic, and yet not become introspective or discouraged, you make the greatest possible use of your native resources.—*Selected*

A Dynamic Health Program

AN ENORMOUS upsurge of interest in the development of a more comprehensive health program for the people of Canada greeted the announcement made on May 14, by Prime Minister Mackenzie King in the House of Commons. The proposed federal grants of $30,000,000 annually for the next five years will provide the impetus for important advances in the development of hospital construction and health services generally. A share in these grants is available to all provinces, providing they maintain their own expenditures for these purposes at the present level or better.

In describing the new National Health Program at the convention of the Canadian Public Health Association in Vancouver last May, the Honorable Paul Martin, Minister of National Health and Welfare, predicted the following distribution of the grants:

1. *The Health Survey Grants:* These grants, totalling $625,000, will make it possible for each province to establish the planning machinery that will be necessary before it can adequately survey its existing health needs, lay its plans for the expenditure of the National Health Grants, study the extension of its hospital accommodation, thd prepare the proper organization of hospital and medical care insurance.

2. *The National Health Grants:* These eight grants broadly cover the entire field of public health. In the first year, they will total as much as $17,000,000, but they will later rise to approximately $22,000,000, and continue indefinitely at that rate.

3. *Grants for hospital construction:* These federal grants of $13,000,000 a year will act as a powerful incentive to hospital building. At the end of five years, the provincial needs will again be surveyed, and it is expected that the grants will continue for a further period of five years, probably at the rate of $6,500,000 a year.

The National Health Grants will make possible a very much broader planning and organization of health facilities. There will be increased sums available for tuberculosis control, for mental health care, for venereal disease control, for the care of crippled children, for professional training, and for public health research. Two special features of the announced program include a proposal to match provincial costs up to $3,500,000 annually for the diagnosis and treatment of cancer, and the offer of $13,000,000 a year in outright grants to aid in the construction of additional hospital accommodation. The latter provision carries the stipulation that the federal contribution must not exceed one-third of the cost per bed in any project.

No special provision is made in these proposals for ways and means of securing the necessary nursing personnel to staff the additional hospital wards or the various public health developments. The need for a greatly augmented corps of qualified nurses is so obvious that the inclusion of some support is being urged by our national and provincial nursing associations. It may be inherent in the plans but strong representations are being made to give the project of the training of nurses a key position in maturing plans. Turn to Notes from National Office and read the brief which was sent by our National president and general secretary to the Federal Minister of Health and Welfare. The points included in this brief are important to every nurse in Canada.

Accidents cause more deaths among children from 1 to 14 years of age than do pneumonia, diarrhea, enteritis, whooping cough, diphtheria, measles, spinal meningitis, infantile paralysis, and scarlet fever combined.—*National Conference on Home Safety*

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Nursing Services in Rural Hospitals

MARJORIE GORDON

WHEN I was asked to prepare a paper giving a "Critical Study of the Nursing Services in Rural Hospitals" I was at a loss as to where to begin. There seemed so many angles of approach that I was in a mental haze. These comments and suggestions have been drawn from personal experience, from matrons of the other rural hospitals, from nurses who have worked in rural hospitals, and from our local doctors.

When we visit some of the newer municipal hospitals, we are immediately impressed with the improved facilities for nursing convenience, patients' comfort, and how the problem of cleanliness has been simplified. In some of our older hospitals the ward doors were too narrow to allow a bed to be moved in or out. Corridors were too narrow, wards poorly lighted, poorly ventilated, and so small that it was very difficult to do anything but make up the bed. Even intravenous medication in such cramped quarters was a major undertaking. The utility rooms are truly something apart. In "L" or "T" shaped hospitals, they are usually located near the angle of the L or T, as far away from the public wards where most of the patients are, as it is possible to get them. This entails a great deal of extra walking for the nurses. The older type are too small and poorly furnished. What equipment there is seems to be piled together making it difficult to use or keep clean.

When an ill person lies in bed with nothing more on his mind than his own sad plight, noise is possibly the most annoying thing, excepting bedpans, that he has to endure. No provision was made for sound-proofing the older hospitals. In our hospital, a word spoken at the entrance can be heard throughout the entire place. When babies are crying in the nursery, a patient is in the labor room, the doctors and possibly a nurse gather in the kitchen for coffee, there is usually a most disconcerting conglomerate assortment of sounds which can be heard throughout the building, with the result that patients, especially the nervous or recent operatives, are disturbed and it's lights-lights-lights! Might I say here, if a nurse had been consulted when hospital plans were being drawn, much of this time-wasting and unnecessary confusion could have been eliminated. Would it not be to the advantage of all concerned if we could have an experienced nurse consultant appointed for this purpose?

Nursing problems in urban and rural hospitals have much in common, but there are many factors that are peculiar to each. General duty nurses

Miss Gordon is superintendent of nurses at Lacombe Hospital, Alberta.

in urban hospitals are assigned to one floor or department — medical, surgical, obstetrical, etc. The general duty nurse in a small hospital cares for a smattering of all types of patients at the same time. She is often confronted with situations in nursing and administration that in large hospitals are dealt with by supervisors, doctors, internes, or administrative staff.

For a moment we will look into the operating-room. There is only one or perhaps two doctors who work in this hospital. One doctor is giving the anesthetic while the other is operating. His first and only assistant is a nurse. This picture is not an unusual one. So many times there is only one nurse on the staff or the matron who has had sufficient surgical training to fit into the picture. In training, it was not very often that we got more than a peek into the incision during an operation. This surgical training, whether acquired while in training or through the school of experience, is of very great importance when working in a rural hospital.

The duties a nurse is called upon to do are numerous and varied. Not the least of these is first aid and minor surgery. The immediate treatment of accident cases rushed into hospital, the control of hemorrhage, shock and the care of lacerations and wounds prove a nightmare to too many of our nurses. They do not lack intelligence but they have just never had the opportunity to develop enough experience.

In obstetrics the lack of opportunity for the practical application of the nurse's usually good theoretical background is sometimes not only embarrassing but a source of considerable worry. It is a thrill that comes once in a lifetime when one of these young nurses finds herself a full-fledged obstetrician all of a sudden, because babies will come, when they will come. Many a recent graduate working in a small hospital has experienced the acme of suspense when frantically holding a head back while another nurse is just as frantically trying to waken the telephone operator in order to call the doctor. On the other hand, it is sometimes very embarrassing to get the doctor out of bed two or three times in the early hours of the morning to deliver an immediate case when a cystocele was the cause of the alarm. These things happen in small and large hospitals but it is the nurse with some practical training and resourcefulness who proves most valuable in rural hospitals.

Laboratory and x-ray demands are seldom in sufficient volume to call for the service of a full-time technician and it is a happy day when I can engage a nurse who is able to do the simple lab. tests required and who, in an emergency, can take an x-ray.

The suggestion has been made that nurses in their final year be sent to rural hospitals for one or two months as part of their final training. This suggestion has been amplified by nurses on my staff who have come to me directly from training. They have told me how much new experience they have obtained and how they have learned to accept responsibility in the first few months in a rural hospital. If this experience were obtained before graduation it would be even more valuable to a nurse in whatever field she chose later.

In large hospitals, the patient is usually merely a name or a number, except to his immediate ward contacts. This is due, of course, to the volume of work and number of patients involved. In rural hospitals, the situation is almost reversed. Every admission is, or becomes, a personal acquaintance of the matron, nurses, nurses' aides, even the cook. Were it left at this the situation would not become too complicated but it is not. The friends and relatives, who presume on that acquaintanceship, flock in to visit at all hours of the day and night and so confuse the confusion. Tact in dealing with such a situation is a gift, and happy is the matron with nurses on her staff who are so gifted. We have rules and regulations, of course, but who has the heart to turn away a visitor who has perhaps made a twenty or thirty-mile trip through

mud or snow to visit a friend and due to car trouble has been delayed? Rural hospitals sometimes are like a large family and, like large families, there is always one who takes too much butter or wants the lion's share of toast and jam.

The relationship of doctors to the staff may mean the difference between a happy family or a staff divided among itself. One demanding doctor may be the cause of severe disruption of an otherwise well-organized, smoothly-working unit. In most instances the doctors are very courteous and considerate to all. The relationship of the superintendent to the nursing staff, secretary, nurses' aides, cook, laundry help, and janitors is perhaps one of the most important problems any matron has to face. The nursing care of the patients largely depends upon and is facilitated by the smooth co-operation of all. Tact, understanding, and ability to lead, and be obeyed when orders are necessary, are of prime importance. Knowing what must be done and how to do it, with a knack of helping to get it done, helps in no small measure. The close relationship of nurses and matron is, of course, inevitable when living under the same roof, and the maintenance of the even trend of congeniality depends equally upon each individual. When such a happy state of affairs does not exist, nurses do not stay in one hospital for any length of time. In some cases, the matron has found it more comfortable to move further afield. The welfare of the nurses, their social life and, to some extent, their personal comfort all lie within the province of the matron's duties. The danger of such a situation, however, is that it may be overdone, resulting in unhappy and even disastrous repercussions.

To promote a better understanding, staff conferences are of great value. They may take the form of regular meetings or informal discussions. Ours are usually the latter, at night when we are spending a quiet evening in our home. It is at this time that many of our working and social problems are ironed out. I have received valuable suggestions from the nurses, and I find that when they know and understand the difficulties confronting the matron, secretary, and board, they are only too willing to co-operate.

I come now to the problem of nurses' accommodation and social life in small communities. This is, to my mind, of very great importance. Furthermore, I am satisfied it is one answer to the question of why one hospital can always keep a full staff while another is never fully staffed and the nurses stay but a short time. Contrary to a somewhat general belief, nurses are human beings, yes, *very human beings!* As such they are surely entitled to the freedom and privileges enjoyed by the general public. Nursing quarters are usually situated upstairs above the wards or down in the basement and every sound is heard in the sick ward. The going and coming of every nurse is carefully recorded by the patients and it does not lead to a sense of freedom or comfort to the nurses so situated. It is not exactly a humorous experience for the nurse who takes her shoes off and creeps up the stairs in the early hours of the morning to be told by her pet patient when she goes on duty in the morning that she came in awfully late and made a terrible noise. Fortunately, we have a very fine nurses' home — a separate unit with all modern conveniences. The nurses are encouraged to make this truly their home. They are able to lounge around in off hours, free from hospital atmosphere, make lunches, have parties and entertain their friends.

No paper covering this subject would be complete without a few remarks concerning the hospital board and the secretary-treasurer. Few who have not had dealings with hospital boards realize the responsibility and burden these public-minded men are called upon to carry. All have the welfare of the hospital uppermost in mind. The board usually consists of three to five men who meet every month. These meetings are quite an event. All business pertaining to the hospital is discussed — the problem of insufficient bed space; new equip-

ment to be purchased; matron's report; the matter of salaries (at this time refreshments are usually served for, after all, the way to a man's heart is reputedly through his stomach). I find that reasonable requests are graciously granted. A good secretary-treasurer proves to be a friend indeed, not only to the matron but to the nurses in general. It is through him that many problems outside the sphere of medicine are overcome. However, do not do as I am forced to do — relegate him to a room in the basement where he works in splendid seclusion. If possible, have his office next to yours where he is convenient to patients on admission and discharge, and to the nursing staff.

If this article has given the impression that our nurses' training is inadequate or that the quality of nurses is not up to standard, it is far from my intention. However, if we are content to stand pat on our achievements, we are bound to slip backwards; we cannot stand still, we must go forward. I am very grateful, indeed, to the urban hospitals and their schools of nursing. Without them and the nurses they send us we would be in a sorry state in our rural communities and hospitals. I am very proud of our nurses. We have the finest type of young womanhood — girls who are willing to spend three years of work and studies to enter a profession where hours are long, work is hard, worries plenty, and where many a time a laugh hides a tear. Her reward, she knows, lies in the satisfaction of work well done or, perhaps, a husband, then a baby and then her nursing starts all over again!

How to be a Better Boss

Addressing the Canadian Retail Federation recently, Dr. E. V. W. Read, noted American retail consultant, discussed the problem of employer-employee relations from the angle of the personal relationship between workman and boss.

Stressing the importance of the human factor as an aid to productive efficiency in an organization, Dr. Read compared the problem with that currently existing in world affairs. Dictators plan *for* their people while the leaders of democratic nations plan *with* theirs. The significance of this difference is reflected in the greater efficiency democracies possess. Even when there is a greater productive potential in the form of extensive raw materials and a plentitude of available workers, regimented nations are invariably handicapped by their very methods in achieving real prosperity.

Every commercial field can point to business men within it who represent extremes of policy in employee relations from the friendly to the callously cold. And statistical charts demonstrate the fact that efficiency is directly related to the degree of good relations existing in any firm.

The thirteen questions listed below were offered by Dr. Read as a kind of check list for employers who seriously wished to estimate their standing in the field of employee relations:

1. Do I give praise where it is due — promptly, willingly, publicly?
2. Do I reprimand in private, saving the other fellow's face?
3. Do I minimize minor mistakes or do I magnify them?
4. Do I take my share of the blame for a blunder — or more than my share, since I am the boss and can afford to do so?
5. Do I shun favoritism and treat all my people equally?
6. Do I refrain from taking my own troubles out on my staff?
7. Do I hold my temper and get the facts before I act?
8. Do I make clear to my people the what and the why of his job?
9. Do I take my employees into my confidence and plan with them, not for them?
10. Do I really encourage suggestions by my attitude and appreciation?
11. Do I depend upon enthusiasm and goodwill rather than fear and authority?
12. Do my employees like and respect me — or do they fear me because I'm the boss?
13. Am I the kind of a boss I would like to have?

— *Health News*

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Opportunities for Health Education in Industry

MARY ROWLES

THE NURSE in industry is able to find an unlimited number of opportunities for health education, some of which she is able to utilize, and others which, unfortunately, she is obliged to give up as unobtainable, although existent. In order to understand this unusual situation, it is first necessary to understand the circumstances under which the nurse works, and the group with which she comes in contact.

First of all, it must be understood that the nurse in industry finds herself in a position entirely different to others in the profession, in that she is possibly the only representative of the nursing, and even of the medical profession, working with large numbers of people employed in other trades and occupations, whose objective is to maintain and to increase production. This has the advantage of making the nurse the only authority on medical matters in the plant or factory, but it also has the disadvantage of leaving her without allies in the face of large numbers of people whose knowledge of medicine ranges from a fairly intelligent level to that of downright ignorance. This is a challenge from the start, but it sometimes becomes rather more of a challenge than it is possible for one individual to meet. I would like to say here that I am speaking from the viewpoint of a nurse working in a plant which averages 450 employees, and which has only one nurse and no doctor. The plant is situated in a small town, about seven miles from the nearest city, from which a large number of employees commute daily, and where the nearest hospital and medical facilities are found. This, of necessity, places the nurse rather more on her own than is the case in other plants where larger staffs are maintained. Certain problems mentioned here are peculiar to this particular situation, and are not to be understood as applicable to all industrial medicine.

The nurse in industry comes into contact with a large group of employees, ranging from the manager to the watchman at the gate; from the superintendent of the factory to the floor sweeper; from the office manager to the lunchroom attendant. Roughly this group may be divided into two parts known as management and personnel, but within each we find many ramifications and classifications. A nurse can only compare any given situation to that prevailing in a hospital, and in many ways a plant and a hospital are similar. For example, we have the manager, who might be compared to the superintendent of nurses; the factory superintendent to the assistant superin-

Until recently, Miss Rowles was employed as an industrial nurse with a firm in Alberta.

tendent of the hospital; the department heads to supervisors, and the foremen to head nurses. Here the similarity ends as differing from the hospital scene where all have certain basic education, interests, and background in common; in the plant we find all levels of intelligence and education, and a diversity of backgrounds —cultural, religious, racial, and moral. This means that the nurse has to deal not only with a well-educated accountant or salesman, but also with the illiterate laborer; with the skilled tradesman, and with those of foreign extraction, steeped in the customs and traditions of their native land. She contacts them daily for a short period, and then they go to their homes and families, where they lead existences often beyond the imagination of any one individual, returning to work with a fresh viewpoint, to engage in tasks in which they are proficient, and in which the nurse is merely an onlooker. It is her problem to enable this mass of individuals to be and to remain healthy so that the wheels of industry may continue to revolve.

It is impossible in the space of a short article to give in detail any plan for health education in industry, and for that reason I have chosen two factors in the industrial program, which I have found to be the most effective.

I have found by experience that the personal interview in the First Aid Department is the most effective means of establishing contact with the worker. At first it seems an insurmountable objective — that of meeting and learning to recognize four to five hundred individuals who are always changing, as the turnover in industry is great. Many may remain for years, but there are others whose stay is of a few weeks or even a few days' duration. However, all employees sooner or later arrive at the First Aid Department, and it is surprising how quickly personalities are recognized and facts about individual backgrounds are discovered. A visit to the nurse to obtain treatment for a cut hand often provides the opportunity to discuss a dietary problem; and a request for aspirin made more frequently than is usual may lead to the discovery of unexplained headache, with consequent examination by the oculist and the prescription of glasses. The nurse must have an accurate and retentive memory, so that facts of past medical history may be reviewed with the workman, and the correct advice given.

In most plants a pre-employment examination with annual check-up is now the custom, and this provides the nurse with a certain basic knowledge of the patient before he makes his complaint; but in a situation such as my own it is necessary to elicit the facts as the situation arises, without the help of a doctor. It should be stressed in this regard that first aid is probably a minor part of the work of the nurse in industry. It is true that at the time of serious accident she is indispensable, but most of the minor cases could be treated by an attendant under the supervision of a nurse. For every case requiring first aid treatment, I think it is permissible to say that at least five present themselves at the First Aid Department, asking for other advice and treatment varying from a request for a laxative to the individual who has discovered certain symptoms and does not know how next to proceed. To assist these patients, appointments are made with family doctors and dentists, and simple treatments are carried out; patients are sent home or taken to hospital; family problems are discussed and advice given.

In connection with those workers who have to stay home because of illness, it is customary in most plants that, after a period of three days, the patient is visited by the plant nurse. This visit is to discover the cause of illness, to investigate the living conditions of the worker, and to be sure that he is receiving the best of care. In many cases workers live alone in rooming-houses, and often the plant nurse is the only person who cares enough to visit them, and to see what can be done for them. It is not usual for bedside care to be given, unless

it is indicated as an emergency measure, but rather to see that provision for suitable care has been made and, if not, to arrange that this is provided. It is sometimes difficult to assure certain types of workers that the visit is altruistic only. Many of them look upon the nurse as a kind of minor-Gestapo, sent out by the management to detect malingerers and, unfortunately, this situation does arise from time to time. I suppose that any industry has a certain group that uses the excuse of illness whenever it requires an extra day off, but actually the nurse should not be concerned with these. It is very disconcerting to find that one has been relegated from the role of "ministering angel" to that of "private detective," and it takes a long time to overcome this reaction in employees. When a satisfactory relationship in connection with home visits has been established, the advent of the nurse will be welcomed. Each visit will give her an opportunity to study the worker and his family, to observe him in his familiar setting, and frequently to furnish answers to otherwise unexplained problems. It is often possible for the nurse to make recommendations for better living, and to point the way to more healthful practices. Sometimes the nurse is the deciding factor in the age-old argument of whether or not to call the doctor, and her objective view of conditions as they exist places her in the best position to see flaws which are invisible to members of the household. Often it is her privilege to solve problems in connection with family allowances, pensions, relief, etc., and for this reason it is essential that she be well acquainted with the local government and the facilities it provides. Special attention is paid to pensioners, either D.V.A. or Workmen's Compensation Board, and to those who are receiving compensation for injury. These visits will sometimes be accompanied by shocks, but one does eventually know "how the other half lives."

These two phases of the work of the nurse in industry are, to me, those which present the greatest opportunity for health education. It is possible to supplement these with visual aids in the form of posters, pamphlets, films, etc., but I feel that in any type of education it is the personal touch of the teacher that counts, and for that reason I stress the personal interview and the home visit.

I may have given the impression that the interview and visit are followed by miraculous results. If that is so I want to say that it is not the case at all. There are many forms of opposition to be encountered, most of which are only too well known to any nurse who has ever been engaged in public health work. In industry, the greatest drawback is presented by the ignorance of the principles of healthful living on the part of all with whom the nurse comes in contact. In varying degrees it is present in each one, and it requires more than the efforts of any one nurse to overcome this obstacle.

On the other hand, industry presents perhaps more freedom and scope for the nurse's work than is found in other fields. When I first reported for work at my present position, I was told by the factory superintendent that I was allowed to go anywhere in the plant, and that in matters of health I had the last word. These are two concessions for which I have been very grateful and on which I have relied. The status I was given — that of department head, so that I was responsible only to the manager and superintendent of factory — has made it easier to deal on suitable terms with the large group with whom I come in contact. It shows that the position of health worker has come to be recognized as equal to those more closely connected with production, which is naturally of primary importance. Indirectly the nurse contributes towards the maintenance of production by keeping the workers healthy, and by maintaining their well-being both physically and mentally. Through cooperation with every member of the plant, and by attending to her own field of work, the nurse in industry may build for herself a permanent and enviable position.

A Specific, Simple Nutrition Effort

E. W. McHenry

Since 1939, and especially during the war, there has been a great deal of nutrition publicity and propaganda. The main type of publicity has been devoted to attempting to educate people to consume six or seven foods or types of foods. In Canada, educational efforts have revolved around a set of recommendations called "Canada's Food Rules." How successful have the efforts been? Since 1939, until recent price changes, there has been an increasing total consumption of milk and this may be attributed to educational efforts *plus* real improvement in economic conditions. Yet surveys on children in the past two years have indicated that about 30 per cent of Canadian children receive much less than the sensible recommendations of one pint a day. Vitamin D, the preventive of rickets, has been known and has been available for over twenty years yet there is an indication that 9 to 10 per cent of present public school children show evidence of having had rickets. Every survey of Canadian children in recent years has shown that nutritional conditions need marked improvement. This situation exists in one of the two most fortunate countries in the world, a country in which healthful foods are available but not adequately used. The primary problem is education.

Are current efforts in nutrition education effective? To a partial extent the answer is "yes" but it is becoming increasingly evident to many who have to deal with the public that changes in procedures are advisable. Canada's Food Rules are correct nutritionally, they appear simple to nutritionists, but they are too complex to those portions of the public who need education. Educational efforts have not only been too complicated but they have been too diffuse; they have lacked a simple, concrete objective. Everyone would realize the undesirability of trying to teach the rules of grammar in one operation; that is the procedure which we have been attempting in nutrition. To add to the problem, different rules of nutrition have been taught by different agencies. Even in a simple matter like recommending milk for children, widely different quantities have been recommended.

The time is ripe for an examination of educational procedures and for planning a simple, concrete campaign to accomplish a definite objective. High prices have focused attention on the purchase of foods and mothers are urgently in need of simple advice on the feeding of children. What is the best objective? Most adults follow fixed food habits which are difficult to change and improper nutrition has already done its damage. Food habits are formed in childhood and children are the most promising targets for a concerted effort. Unified efforts to improve the nutrition of children by every possible agency could accomplish what divided, diffuse, and complicated efforts have not achieved. If the campaign is to succeed it must be simple and possible of achievement. The final result can be best obtained a few steps at a time. A very useful start could be made by trying to see that every Canadian child receives a pint of milk a day plus the accessory nutrient, vitamin D, in amounts of 400 to 800 units daily. These two recommendations would provide an adequate amount of calcium and the vitamin D would ensure the utilization of the calcium. A third suitable recommendation would be a source of vitamin C. The feeding of an infant begins with these three constituents — let us urge mothers to continue them. When this limited objective has been achieved, additional measures could be taken to finally secure healthful nutrition for every Canadian child.

Dr. McHenry is professor of public health nutrition at the University of Toronto.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Jubilée d'Or

L'ÉCOLE des infirmières de l'Hôpital Notre-Dame, la première école d'infirmières de langue française, fêtait le 19, 20 et 21 juin 1948, le cinquantenaire de sa fondation. Des fêtes splendides marquèrent cet événement.

C'est en 1898, dix-huit ans après la fondation de l'hôpital, que s'ouvrit l'école. L'hôpital comme l'école étaient sous la direction des Soeurs Grises de Montréal. La première directrice, la Révérende Soeur Elodie Mailloux, infirmière diplômée de l'Hôpital St-Vincent de Toledo, Ohio, était une femme supérieure. "Ses qualités d'esprit, sa largeur de vue, la sureté de son jugement, joints à un profond esprit religieux, lui faisaient une personnalité remarquable."

Dès son arrivée à l'hôpital, elle décida que les religieuses, qui avaient déjà une connaissance pratique du soin des malades, devaient y ajouter des connaissances scientifiques, en vue de la formation des infirmières laïques. Le 13 juillet 1899, onze Soeurs Grises recevaient leur diplôme d'infirmière. La première étudiante laïque fut admise le 1er octobre 1899 et la classe de 1900 se composait de sept élèves.

A l'hôpital, les lits de cinquante, au moment de la fondation, étaient passés au nombre de 125 en 1900.

Les notes et renseignements sur l'hôpital et l'école sont extraits du volume publié à l'occasion des fêtes— "L'Ecole d'Infirmières de l'Hôpital Notre-Dame" par Madame A. Ferland Angers, juin 1948.

Le cours était de trois ans, avec les matières suivantes au programme:

1ère année: 12 leçons en anatomie et physiologie; 6 leçons en hygiène; 12 leçons en matière médicale; 6 leçons en bactériologie et stérilisation.

2e année: 10 leçons en petite chirurgie; 8 leçons en gynécologie; 7 leçons en médecine générale; 2 leçons en anatomie de l'oeil, nez et oreille; 1 leçon en hygiène de ces organes; 3 leçons en hygiène de la peau; 3 leçons en soins aux enfants.

3e année: 3 leçons en soins des enfants; 8 leçons sur le soin des accouchées; 4 leçons sur l'analyse des urines; 10 leçons sur la cuisine des malades; 6 leçons sur la direction des salles; 3 leçons sur l'étiquette professionnelle.

Le premier manuel, résumé de toutes les matières enseignées, fut l'oeuvre de la deuxième directrice, la Révérende Soeur M. A. Duckett.

L'enseignement clinique, au lit du malade, fut introduit par la Révérende Soeur Fafard, femme d'une rare vision. Ce fut elle qui fit les démarches nécessaire pour faire reconnaître l'école par l'Association des Gardes-Malades Enregistrées de la Province de Québec.

Les heures de service étaient de 7:00 a.m. à 7:00 p.m. et le service de nuit se faisait tout d'une traite de 7:00 p.m. à 7:00 a.m. sans repos et durait six mois d'affilée. C'était l'usage partout (détail amusant) parce qu'il en était ainsi à l'Hôpital Général de Montréal.

La première affiliation date de 1908. Les élèves font un stage d'un mois à la maternité de la Miséricorde; 1920, ce stage est porté à quatre mois.

L'on ne peut mieux juger le travail accompli par les directrices et les pro-

La résidence des infirmières.

grès réalisés par cette école qu'en comparant les rapports des visiteuses officielles de l'Association des Gardes-Malades Enregistrées de la Province de Québec. Mlle Samuel rapporte en 1922 que les soixante-huit étudiantes couchent en dortoirs, qu'elles n'ont ni salle d'étude, ni laboratoire, ni salle de démonstration, que la bibliothèque documentaire est mince, etc. Il faut croire que l'on avait cessé à l'Hôpital Notre-Dame de faire les choses "parce qu'elles se faisaient ainsi à l'Hôpital Général de Montréal." En 1926, les progrès sont si marqués que la présidente de l'Association écrit une lettre des plus élogieuses à la directrice. Aujourd'hui, l'école, qui compte deux cents élèves, possède une résidence des plus modernes, une bibliothèque, des laboratoires, etc. La directrice des études est la Révérende Soeur Rheault, bachelière en science hospitalière. Cinq institutrices, dont deux bachelières, l'assistent dans sa tâche.

Les activités de quelques diplômées de l'Hôpital Notre-Dame furent assez remarquables. Presque toutes les religieuses diplômées de l'école sont devenues directrices d'écoles d'infirmières dans les hôpitaux de leur communauté respective. Les quatre premières directrices de l'Hôpital Norman et Cross à Trois-Rivières étaient des diplômées de Notre-Dame, les deux premières directrices de l'Hôpital Ste-Justine de même. La directrice de la revue *La Garde-Malade Canadienne-Française* est une diplômée de Notre-Dame; elle dirige en même temps le Sanatorium Prévost. Une infirmière de Notre-Dame organisa le service d'infirmière de la Métropolitan. Le registre Ville-Marie fut organisé par elles. D'autres ont porté le renom de l'école comme institutrices à l'étranger — à Paris, aux Etats-Unis dans diverses institutions du pays. A la guerre de 1914 comme à la guerre de 1939, les infirmières de Notre-Dame formaient des groupes importants.

A l'ouverture des fêtes, son Excellence Mgr. Charbonneau souligna les magnifiques résultats qu'avaient apportés dès le début de la fondation, l'initiative, la co-opération des laïques et des religieuses et donna en modèle cette réunion.

Le souvenir des fondateurs, le Dr Lachapelle, de la Révérende Mère Mailloux, et de Madame Thibodeau, première présidente des dames patronnesses, fut évoqué par le Dr Albert Lesage, doyen des médecins. Un hommage, reconnaissant des malades de l'hôpital et des médecins, fut présenté par le Dr Georges Hébert, président

"Hosanne à Notre-Dame"

du Bureau Médical. Une magnifique Cantate "Hosanne à Notre-Dame" fut chantée par les élèves.

L'école heureuse de son succès, fière de ses diplômées, "voulut détacher de sa couronne d'or quelques feuilles de ses lauriers et les offrir"; comme il était impossible de partager cette couronne avec toutes, trois diplômées furent choisies pour représenter les divers groupes. Mlle A. Morin, classe 1904, doyenne, première diplômée à faire connaître le nom de Notre-Dame à l'étranger, et Mlle A. Lépine, présidente de l'Association des Gardes-Malades de Notre-Dame, représentait les infirmières du service social. Mlle S. Giroux, visiteuse officielle des écoles, représentait celles qui se sont dévouées à l'éducation et ont pris part à la guerre.

Le lendemain, l'école qui compte depuis sa fondation 1,245 diplômées dont 150 religieuses, voyait plus de 650 de ses anciennes réunies pour assister à la messe dite par l'Archevêque de Montréal et au dîner offert par l'Hôpital Notre-Dame.

Les décorations, vraiment artistiques, étaient l'oeuvre de Mlle Vincent, diplômée de l'école.

La clôture des fêtes eut lieu le lundi — messe de requiem, déjeuner, et clinique par le Dr Bertrand sur le neurochirurgie.

Mlle A. Martineau, représentante de la présidente de l'Association des Infirmières de la Province de Québec, eut un mot très heureux, qui fit grandement plaisir aux invitées. Elle remercia, au nom de la profession, les infirmières de Notre-Dame, rappelant que la profession leur devait beaucoup.

Cette fête de famille réunissait les enfants venues de partout—des Etats-Unis, de Victoria, Calgary, Winnipeg, de l'Ontario, Chicoutimi, Rouyn, La Tuque, Gaspésie, etc. Toutes étaient heureuses de venir offrir leurs hommages de reconnaissance, de renouveller connaissance avec les compagnes, et d'offrir à l'école des voeux de succès et de longue vie.

A la supérieure, Soeur Plourde, à la directrice de l'école, Soeur Marcil, les remerciements les plus chaleureux ne sauront dire la joie de ces fêtes.

Women attending college a half century ago had smaller feet than women students today, their feet averaging 9.2 inches as compared with the present length of 9.4 inches. Likewise the feet of men in colleges from 1880 to 1910 were, on the average, two inches shorter than they were for the period 1920 to 1940.

Nursing Profiles

Eleanor Jean Martin, who was appointed as the first instructor with the Metropolitan School of Nursing in Windsor, Ont., operating under the Demonstration School Administration Committee of the Canadian Nurses' Association and the Canadian Red Cross Society, has been named as assistant director of the school.

Born and educated in Moose Jaw, Miss Martin received her B.A. from the University of Saskatchewan in 1929. After several years of teaching she enrolled in the school of nursing at the Royal Victoria Hospital, Montreal, graduating in 1940. On completion of the certificate course in teaching and supervision at McGill University the following year, Miss Martin joined the teaching department of her home school for two years. She left there to take charge of the nursery at the Methodist Hospital in Los Angeles, Calif., and served also in the Harriman Jones Clinic Hospital in California before becoming clinical supervisor at the Calgary General Hospital in 1946.

For relaxation Miss Martin enjoys her game of golf, swimming, and bridge.

The second appointee on the Metropolitan School of Nursing staff was **Eleanor Scott Graham** who was appointed health instructor with responsibility for the student health program.

Born in New Westminster, B.C., Miss Graham graduated from Vancouver General Hospital and received her degree of Bachelor of Applied Science from the University of British Columbia in 1936. After eight years of official public health nursing organization work with the Metropolitan Health Committee in Vancouver and the Provincial Department of Health of British Columbia, Miss Graham went to the University of Chicago where she obtained her Master of Science degree in 1945. For the past two years she has been second assistant superintendent at the National Office of the Victorian Order of Nurses for Canada. Miss Graham has taken an active part in nursing organization work both in British Columbia and Ontario. Her chief interests, outside of her regular work, include music, reading, bridge and, for outdoor sport, skiing.

Marjorie Pinchbeck, who graduated from the Calgary General Hospital in 1939, has been appointed associate director of the school of nursing at McMaster University, Hamilton. Following a brief period of general duty activity, Miss Pinchbeck secured her public health nursing certificate at the University of British Columbia and returned to Alberta as district nurse at Sunnynook. For two years she was on the school nurse staff

Stillings, Calgary

ELEANOR MARTIN

Sherick, Toronto

ELEANOR S. GRAHAM

MARJORIE PINCHBECK

of the City Health Department in Calgary after which she enrolled in the course in supervision and public health nursing at McGill School for Graduate Nurses.

In 1945 she joined the staff of the Ontario Health Department serving as supervisor of the Kirkland Lake health unit until June, 1947. She has recently completed the work for her degree in nursing at McGill University. Miss Pinchbeck is a very capable organizer and with her broad understanding of public health activity she will give sound leadership to the students in this field of nursing at McMaster University. When time permits she thoroughly enjoys participation in choral activities. This branch of the teaching faculty at McMaster will bear proof in the years to come of her outstanding abilities.

Henrietta Jane Alderson is lecturer in nursing at the school of nursing, McMaster University. Born in Caledonia, Ont., Miss Alderson graduated from the Hamilton General Hospital in 1938. She secured her diploma in teaching and supervision from the school of nursing at the University of Toronto, following which she returned to her home school as head nurse in the male surgery department. In 1941 she became nursing arts instructor at H.G.H. and in 1943 she joined the staff of the Brandon Mental Hospital as science instructor. In 1946 Miss Alderson received her Bachelor of Science degree from Columbia University.

Her hobbies are many and varied — dressmaking, sewing, needlework, cooking, drawing, sketching, with badminton and hiking for outdoor interests.

Hubert Beckett

HENRIETTA ALDERSON

Rietta Christena Christilaw has been appointed inspector and supervisor of nursing assistants course with the Nurse Registration Branch of the Ontario Department of Health. Mrs. Christilaw graduated from the Winnipeg General Hospital in 1931. Her marriage followed immediately and it was not until 1942 that she returned to active nursing. At that time she became acting registrar of the Saskatchewan Registered Nurses' Association. Later she was on the staff of the Dauphin General Hospital, Man., and the Ottawa Civic Hospital. For a period of four months she assisted with the secretarial tasks at the National Office of the Canadian Nurses' Association in Montreal. For nearly two years she was assistant registrar with the Central Registry of Graduate Nurses in Toronto.

MRS. R. C. CHRISTILAW

Tony Archer, Vancouver

KATHLEEN PANTON

Most of Mrs. Christilaw's leisure is taken up with the work in her own home. She is fond of bridge, sewing, knitting, and picnics.

Muriel Jean Graham, a native of Antigonish, N.S., a 1932 graduate of the Victoria General Hospital, Halifax, and a former R.C.A.M.C. nursing sister, has been appointed educational director at the school of nursing associated with the Children's Hospital, Halifax. Miss Graham holds her Bachelor of Arts degree from St. Francis Xavier University and her certificate in supervision in schools of nursing from the McGill School for Graduate Nurses. Prior to her enlistment in the army nursing service, Miss Graham was registrar of the Registered Nurses' Association of Nova Scotia for six years. Following her release from the army, she served with UNRRA in China and Formosa.

Miss Graham is fond of reading, preferably sea stories. Among her hobbies she includes the collection of sea poems and stamps. She enjoys good music especially grand opera.

After six and a half years as matron and thirteen years on the staff of the Shaughnessy (D.V.A.) Hospital, Vancouver, B.C., **E. M. Kathleen Panton** has retired. Miss Panton's long nursing career began when she graduated from the Hospital for Sick Children, Toronto. After practising there and in Pittsburg, she went overseas in 1915 with the Canadian Army Medical Corps. She went to France in 1916 and was awarded the Royal Red Cross while serving with No. 1 Canadian Casualty Clearing Station and was mentioned in despatches. She returned to Canada in 1919 for duty at Christie St. Military Hospital, Toronto. A post-graduate course in hospital administration at McGill School for Graduate Nurses was followed by her appointment as superintendent of nurses at the Hospital for Sick Children in 1921. After seven years in this capacity, she moved to Vancouver where she worked as office nurse until she joined the staff at Shaughnessy in 1935. In 1940 she became assistant matron assuming the full responsibility two years later. Miss Panton will continue to reside in British Columbia.

Helen Louise Potts has resigned as superintendent of the Woodstock General Hospital, Ont., after seventeen years of faithful service.

Graduating in 1918 from the Brantford General Hospital, Miss Potts was night supervisor at the Samaritan Hospital in Ashland, Ohio, for two years before returning to her alma mater as assistant superintendent. In 1927 she became assistant in the admitting department of the Hospital of the Good Samaritan, Los Angeles. Since 1930 she has guided the hospital through the troublesome years of the depression and the difficult war years. A great deal of the credit for the high standing of the hospital can be attributed to her untiring efforts on its behalf. The strain of carrying the full load of the hospital contributed to Miss Potts's break in health.

Mary Chalk has retired after thirty years of service as supervisor of the out-patient department at the Women's College Hospital, Toronto. Miss Chalk was the recipient of many favors and gifts on the occasion of her retirement.

Something to Chew On

"For every child a tooth" is an old saying now known to be untrue. There is no good reason to believe that the process of bearing a child must hasten tooth decay, doctors say. But neglect of the teeth before and during the period of pregnancy often causes the loss of more than one tooth as well as much needless suffering.

All dental defects should be corrected early in pregnancy and the teeth kept in good condition throughout this period. Dental treatment is not dangerous.

Notes from National Office

Health Insurance

THE following brief was presented by the Canadian Nurses' Association to the Honorable the Minister of National Health and Welfare, with a copy to the Right Honorable W. L. Mackenzie King, C.M.G., Prime Minister of Canada:

The nurses of Canada are deeply interested in the proposals relating to Health Service and Health Insurance, made in the House of Commons on May 14, 1948, by the Prime Minister, the Right Honorable W. L. Mackenzie King. The nursing profession is keenly appreciative of the far-reaching, beneficial effects which the proposed program will have upon the health and welfare of the people of Canada.

The Canadian Nurses' Association, while stirred and gratified by the prospect of the implementing of this magnificent program, is deeply concerned as to the part which nurses will be expected to play in its development. As professional women and as citizens, our members are both willing and anxious to assist in every way possible in furthering this national health project and wish to offer their wholehearted co-operation to the Department of National Health and Welfare.

We are keenly aware of the increased demands which a national health program will make on hospitals, as well as on public health services and personnel, and we feel, therefore, that the correlation of all nursing services and personnel is of paramount importance. In order that we may participate in the most effective manner in this endeavor, may we respectfully submit the following recommendations for consideration:

1. That the Department of National Health and Welfare establish within the Department, and without delay, a Division of Nursing, and appoint a Federal Director of Nursing.

2. That a National Survey of Nursing be undertaken immediately, with the following objectives:

(a) Estimation of the nature and extent of the need for nursing service of all types, professional and auxiliary, which seems likely to prevail over a period of five to ten years.

(b) Differentiation, by means of a job analysis, between the duties which can safely be performed only by professional nurses and those which may acceptably be performed by auxiliary nursing personnel.

(c) Appraisal of present methods of preparing professional nurses in schools of nursing operated by hospitals. Examination of the desirability of operating schools of nursing under a completely different basis than at present.

(d) Appraisal of present methods of training auxiliary nursing personnel and examination of any modifications which may seem desirable in the light of the job analysis mentioned above.

(e) Analysis of the cost to the hospitals of operating schools of nursing and of the value to the hospitals of the nursing service rendered to them by student nurses.

(f) Exploration of a plan for better utilization and distribution of nurses engaged in private duty nursing.

3. That the grant for professional training should be extended to include the preparation of more student nurses as well as specialized training for graduate nurses.

We note the inclusion of grants for hospital construction as part of the total program. We suggest, therefore, that all plans for additional hospital beds include also plans for augmented residence facilities for the additional nurses required.

In the light of these pressing needs, this submission is also being presented for the consideration of the Dominion Council of Health in meeting June 7, 1948.

Royal College of Nursing

The following are excerpts from the reported activities of the Council of this organization:

The fear of direction: In spite of ministerial assurances to the contrary, it had been reported that, because the majority of hospital nurses are technically the employees of Regional Hospital Boards, some of them feared that they may be liable to direction with the regions. In order to relieve their anxiety the secretary was directed to obtain a statement of the position from the Ministry of Health. A letter was received from Dame Katherine Watt, Chief Nursing Officer at the Ministry, assuring members that they had no cause for anxiety on this score. Though the Boards would, subject to regulations, determine the nurses' remuneration and conditions of service, the functions in respect of their appointment and dismissal would be exercised on the Board's behalf by Hospital Management Committees. The Council felt that the publication of Dame Katherine's statement in the College's official journal would do much to allay apprehension, coupled with the fact that any attempt at infringements of the nurses' freedom by the boards could be promptly and effectively dealt with by means of the new Whitley machinery.

Whitleyism for nurses: This machinery will, it is hoped, provide the means of solving many present nursing problems. The Royal College of Nursing approved the draft constitution of the Nurses' and Midwives' Functional Council, through which, under the National Whitley Council for the Health Services, nurses' conditions of service can be safeguarded. The College's newly established Labour Relations Committee, under the chairmanship of Sir Frederick Leggett, already advises the Council on matters relating to the settlement of salaries and conditions of service, on negotiating machinery, and on all other matters within the field of "industrial relations." This committee is composed of representatives of the Council, sections, and branches within the College.

Insurance and superannuation matters: At the request of the Council, the National Insurance Advisory Committee has agreed to discuss with College representatives their contention that State registered nurses attending post-certificate courses should be excused insurance contributions without loss of benefit. It was also agreed to draw the attention of local authorities to the special application of Regulation 15 of the National Health Service Superannuation Regulations, 1947, to nurses remaining in the service or transferred under the Act. This regulation gives to local authorities discretionary powers to reckon non-contributing as contributing service for superannuation purposes, and to add up to five years to the actual length of service of those female nurses, health visitors, and midwives who, on reaching the age of sixty years, cannot complete forty years' service.

The National Council of Nurses: For some time the College branches have been considering the future constitution and functions of the National Council of Nurses, particularly in the light of a questionnaire submitted by the National Council on the matter. Branch opinion has now been analyzed, and as a result the College Council decided to inform the National Council that, while their branches realized the need for a focal national body affiliated to the International Council of Nurses, they felt that the constitution of the National Council was unsuitable, and its aims and objects more appropriate to a professional organization or union than a federated body whose main function should be the consolidation of national policy. Moreover, owing to the per capita system, the College had to meet financial obligations out of all proportion to the voting strength permitted to an organization of its size. A number of branches feel that the College, with its large, representative membership, its educational and professional policy, its national and international contacts and established public position, should, with certain adaptations, become the national body. However, as this view may not be acceptable to some constituent organizations, the College suggests a thorough inquiry into the position.

Job Analysis

The Nuffield Trust, through its new inquiry, is undertaking a Job Analysis of the work of the nurse and of the other members of the health team. "What is the proper task of the nurse?" is the question the Nuffield Trust proposes to answer. What is the nurse's share in the whole service needed by the patient in hospital or in the full health team providing that service? The Nuffield Trust believes the nurse to be the focal point of efficient service to the patient and, because of this, the attention of its Job Analysis team is to be concentrated on her.

This analysis is to be conducted by a specially picked team, led by a mem-

ber of the Oxford Regional Hospital Board, and by two women psychiatric social workers.

Some of the questions to which the Nuffield survey hopes to find the answers are as follows:

1. How can the efficiency of the nurse (and the whole health team) be improved?

2. Is the nurse failing to give full service to the patient because her energies are dissipated on time-wasting tasks which should not rightly be hers anyway?

3. Is her efficiency impaired by too long hours on duty?

4. In view of her constant exposure to infection, is her health adequately safeguarded, or is she too frequently herself on the sick list because her resistance is lowered through insufficient sleep and nourishing food?

5. Is the whole atmosphere of the nurse's life clouded by slavish adherence to an out-of-date regime of hospital discipline; if so, does her work suffer and, consequently, is the patient also the loser?

Training Within Industry

According to May 22 issue of *Nursing Times*, Training Within Industry (T.W.I.) would certainly seem to have a place of value in the hospital world. Great progress has been made in industrial conditions in all sorts of ways. With the concentrated attention paid during the war to working conditions and personnel management, several schemes were developed which may prove of value also in the hospital field.

Job Relations Instruction is based on the fact that there are various grades of staff in every sphere of work who are, in all cases, human beings much like each other, whether they are concerned with making aeroplanes or ensuring the smooth running of a hospital ward.

Many people, the editor goes on to say, will think a good administrator is born, rather than made! Psychologists tell us that the art of obtaining satisfactory human relationships can be learned. The head nurse (ward sister), above all, should be skilled in the art, dealing as she does constantly with human beings, whether they are the ill patients or their well relatives, with the student nurses, or with her own colleagues.

Notes du Secrétariat de l'A.I.C.

Les Assurances de Santé

L'exposé suivant fut présenté à l'honorable ministre fédéral de la Santé et du Bien-Etre; une copie en fut aussi envoyée au très honorable W. L. Mackenzie King, C.M.G., premier ministre du Canada: Les infirmières du Caada ont été très intéressées par les propositions faites à la Chambre des Communes le 14 mai 1948, par le premier ministre, le très honorable W. L. Mackenzie King, concernant le service et les assurances de santé.

La profession d'infirmière apprécie déjà, les heureuses conséquences qu'aura sur la santé et le bien-être de la population du Canada, la réalisation de ce programme de santé.

Bien que ce magnifique programme ait suscité l'admiration de l'Association des Infirmières du Canada et l'ait satisfaite, elle n'en ait pas moins concernée par la part que les infirmières seront appelées à prendre lors du développement de ce programme. Comme membres d'un corps professionnel et comme citoyennes, les infirmières désirent et veulent seconder la réalisation de ce projet de santé nationale et offrent de tout coeur, leur coopération au ministère national de la Santé et du Bien-Etre.

Nous nous rendons bien compte que l'exécution d'un programme national de santé exigera des hôpitaux, des services de santé et de leur personnel, une plus grande contribution que jamais, par conséquent, nous croyons qu'il est d'une importance primordiale que le nombre des infirmières soit en relation des services que l'on attend d'elles.

Afin que les infirmières puissent participer

aussi efficacement que possible à cette entreprise, nous soumettons respectueusement à votre considération les recommendations suivantes:

1. Que le ministère national de la Santé et du Bien-Etre établisse dès maintenant une section du nursing et nomme une directrice nationale du nursing.

2. Qu'une enquête nationale soit faite immédiatement dans le but de:

(a) Estimer les soins requis par la population du Canada d'ici cinq à dix ans, l'étendue de ces soins, leur nature, soins donnés par professionnels, par groupe auxiliaire.

(b) Par l'analyse du travail, établir une différence entre le travail qui peut être accompli en toute sécurité par des infirmières et celui qui peut être exécuté par un groupe auxiliaire.

(c) Evaluer les méthodes actuellement employées dans la formation d'infirmières professionnelles dans les écoles d'infirmières dirigées par les hôpitaux. Examiner s'il est désirable d'avoir des écoles sur un tout autre plan.

(d) Evaluer les méthodes actuelles d'entraînement d'aides ou de tout groupe auxiliaire du personnel professionnel de nos hôpitaux et examiner à la suite de l'analyse du travail les changements désirables à apporter.

(e) Analyser ce que coûte aux hôpitaux, une école d'infirmières, la valeur des services donnés à l'hôpital par les élèves infirmières.

(f) Faire des recherches permettant une meilleure répartition d'infirmières, par exemple: Que les infirmières du service privé reçoivent un salaire et soient placées par un hôpital ou un registre là où leurs services sont requis.

3. Que l'octroi versé pour la formation professionnelle soit étendu à la formation d'un plus grand nombre d'élèves infirmières aussi bien qu'à la formation spécialisée d'infirmières diplômées.

Nous notons dans le programme global que des octrois seront versés pour la construction d'hôpitaux; par conséquent, nous suggérons lorsqu'on préparera des plans dans le but d'augmenter le nombre de lits à l'usage des malades à l'hôpital, que l'on tienne bien compte du nombre d'infirmières que ce surplus de lits exigera, et que l'on prépare en même temps les plans nécessaires à l'agrandissement des résidences d'infirmières.

En Grande-Bretagne

Le service national de santé: Une des craintes des infirmières de Grande-Bretagne, du fait qu'elles sont les employées du conseil régional des hôpitaux (Regional Hospital Boards), est celle d'être soumises aux décisions de cet organisme. Afin de les réassurer, la secrétaire-registraire demanda au ministère de la Santé de définir clairement qu'elle sera la position des infirmières.

Le ministère de la Santé, par la directrice du nursing de son département, Dame Katherine Watt, réassura les infirmières sur ce point; elles seront soumises aux règlements du conseil régional des hôpitaux pour les conditions de travail et les rémunérations, mais pour ce qui concerne leur nomination ou leur renvoie, l'autorité du conseil régional sera exercée par l'administration de l'hôpital. Ce communiqué, publié dans le journal officiel de l'association, est une preuve que le ministère ne veut pas entraver la liberté des infirmières.

Le Collège Royal des Infirmières vient d'organiser un comité des Relations du Travail sous la directive de Sir Frederick Leggett, qui déjà a conseillé les infirmières sur les questions de salaires, relations du travail, etc.

Assurance et caisse de retraite: Pour faire suite à une requête du conseil du Collège Royal des Infirmières, le comité national des assurances de santé a accepté de discuter avec des représentantes du Collège, la question suivante: Que les infirmières soient exemptées de payer les assurances santé durant le temps qu'elles suivent des cours post-scolaires et ce, tout en ayant droit aux bénéfices.

Quel est vraiment le travail de l'infirmière? Le "Nuffield Trust" fait de nouvelles recherches. Il entreprend de faire l'analyse du travail de l'infirmière et des autres membres du service hospitalier; l'on cherche la réponse à la question suivante: Quel est vraiment le travail de l'infirmière?

Dans tous les services qui ont pour buts, soit d'assurer à l'individu les services qu'il requiert en cas de maladie ou ceux qu'il requiert pour se maintenir en bonne santé, quelle est la part de l'infirmière? Le "Nuffield Trust" croit que l'infirmière est le pivot de ces services, voilà pourquoi les recherches seront surtout dirigées vers elle.

Un comité trié sur le volet a été choisi pour mener cette enquête à bonne fin. L'on espère par cette enquête trouver une réponse aux questions suivantes:

1. Comment l'efficacité des services de l'infirmière à l'hôpital et dans les services

de santé peut-elle être améliorée?

2. Quelles sont les raisons qui empêchent l'infirmière de répondre à tous les besoins du malade? Est-ce parce qu'elle dépense ses forces à des travaux inutiles, lesquels vraisemblablement ne devraient pas être accomplis par elle?

3. Son efficacité dans les services, est-elle diminuée à cause de trop longues heures de travail?

4. Du fait qu'elle est constamment exposée aux infections, sa santé est-elle suffisamment protégée, est-elle trop fréquemment rapportée comme malade, sa résistance est-elle diminuée à cause du manque de sommeil, à cause d'une alimentation insuffisante?

5. La vie de l'infirmière, est-elle assombrie par un règlement et une discipline datant d'une époque lointaine? S'il en est ainsi son travail en souffre-t-il et conséquemment son malade?

Formation professionnelle au travail: L'expérience faite durant la guerre dans les milieux industriels d'entraîner un personnel inexpérimenté, tout en le faisant travailler a donné des résultats inespérés, si bien que l'on se demande si le plan ne pourrait pas être adopté par les hôpitaux? Des progrès marqués ont été accomplis dans l'industrie. L'on a porté une grande attention durant les années de guerre, aux conditions de travail, administration du personnel, bien des arrangements adoptés dans ces milieux pourraient être adoptés avec avantage par les hôpitaux.

L'on se base dans les "Instructions sur les relations du personnel au travail" sur les faits suivants: Pour accomplir un travail, il faut à tous les échelons des ouvriers différents, mais ils sont tous des êtres humains. Tous se ressemblent qu'ils soient occupés à construire un avion ou à faire une part de travail qui donnera comme résultat un département de malades bien administré.

Bien des gens diront, lit-on encore dans ces instructions, que l'on nait administrateurs, mais les psychologues disent que c'est un art qui s'apprend — l'on peut devenir un bon directeur du personnel. L'hospitalière ou la surveillante doit plus que toute autre posséder cet art, car constamment elle a affaire à autrui, les malades, leurs parents, les élèves, et les infirmières.

McMaster University School of Nursing

GLADYS J. SHARPE

McMASTER University entered the field of nursing education in 1942. This venture was based upon the premise that the university was in a position to assist in the evolution of this form of education from the apprenticeship system, as it had aided with other professions.

The first attempt was in the nature of a co-operative plan between the university and the Hamilton General Hospital, whereby the student obtained her general academic education in two and one-half years of study at the university and her professional preparation, covering a period of thirty-two months, at the hospital. Upon satisfactory completion of both aspects of this program the student was granted the degree of Bachelor of Arts from the university and the diploma of the Hamilton General Hospital School for Nurses. This arrangement was followed for a period of four years and, while not wholly satisfactory, did serve to justify the need for a university school for nurses in this area.

In September, 1946, a study was made of all the available facilities of the community and a general plan mutually acceptable to the institutions concerned was formulated. In November of the same year a tentative program, which would lead to the degree of Bachelor of Science in Nursing, was submitted to the Nurse Registration Branch, under the Ontario Department of Health, and the school of nursing was officially approved.

In the enviable position of laying a foundation upon which a super-

Miss Sharpe is director of nursing education at McMaster University, Hamilton, Ont.

structure could be erected as required, rather than having to remodel one, it was considered advisable to establish a basic professional course which would prepare well-qualified candidates for all types of nursing service and at the same time provide an opportunity for their fullest personal and professional growth.

With our objective established the next step was to secure the tools with which it could be achieved. With the addition of a nursing arts and a nutrition laboratory, adequate physical facilities were available at the university, while those necessary for clinical instruction and experience were arranged through contractual agreements with the hospitals and other community agencies.

The nursing curriculum, designed in terms of our aims and facilities, is built around five general areas, namely: (1) biological sciences; (2) physical sciences; (3) social sciences; (4) the humanities; (5) nursing and related medical sciences. The pattern followed is designated as an integrated five-year plan in which the professional and general education is carried on continuously. The control of the entire program is in the hands of the university, which body is responsible for assuring that educational values are emphasized throughout.

The organized instruction is arranged as follows:

YEAR 1—*Part 1:* Academic year (figures indicate approximate number of hours):

Anatomy and physiology	72
Biblical literature	26
Botany	60
Chemistry	150
English	75
Microbiology	60
Nursing education	26
Psychology	75
Sociology	36
Zoology	60

Part 2—12 weeks:

Health education	24
Nursing arts — lectures, demonstrations, supervised practice	340

YEAR 2—*Part 1:*

Anatomy and physiology	72
Biblical literature	26
Chemistry	72
History	75
Health education	50
Nutrition	50
Nursing education	45
Sociology	36

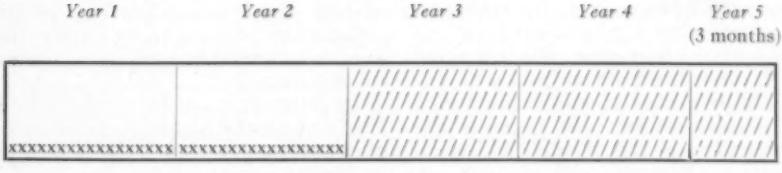
Part 2—12 weeks:

Nursing and health services in the family.

Through affiliation with the Public Health Department, the Victorian Order of Nurses, industry, and the hospitals, the student is offered an opportunity to observe nursing skills as they are applied in the home; to observe the co-operative working relationship of nurses with other community services, and to perfect her nursing skill in selected situations.

The West Lincoln Memorial Hospital at Grimsby, Ont., has been selected as a desirable field in which the student may gain experience in a small community hospital which serves a rural area.

Plan



= 1 year general academic education (2 months' vacation)
/ = 1 year professional education (1 month vacation)
x = Summer term of professional education

YEAR 3: Nursing in medicine — including specialties.
YEAR 4: Nursing in surgery, obstetrics, and pediatrics.
YEAR 5: Elective — clinical or community fields.

Plan of Clinical Rotation

Weeks	1–12	13, 14	15 - 35	36 - 43	44 - 47	48 - 52
Year 3	Psychiatry 12 weeks	V A C A T I O N	Medicine, including O.P.D. clinics and specialties 20 weeks	Tuberculosis inc. O.P.D. clinics 8 wks.	Vac. 4 wks.	Surgery 5 wks.
Year 4	Surgery, clinics and 12 wks.		including O.P.D. specialties 10 weeks	Obstetrics 12 weeks	Vac. 4 wks.	Pediatrics 12 weeks
Year 5	Community or clinical field 12 weeks					

Organized instruction which averages 12 hours per week, including lectures and ward teaching, is given in conjunction with the above clinical experience.

The students of the school of nursing participate in campus activities and in general counselling and other student and personnel services established by the university. Advantage is taken of the highly satisfactory counselling program which is adapted to the specific needs of the nursing students. This program includes a series of psychometric tests given during the first week of the university, the findings of which are forwarded to each adviser. Following the receipt of such reports an appointment is made and the student has the opportunity of discussing the results of each test.

The student in nursing is provided with professional counselling throughout the entire course. This is given by that faculty member of the school of nursing who is working most closely with the student at a given time.

The president of a great university has said that effective leadership in any field depends on the ability to aim at and to hit a moving target. As we examine our target, established over a year ago, we see that it has already shifted and we ask, Is our aim true? Does the curriculum recognize and anticipate those problems which the graduate of the school may meet — as an individual, as a professional worker, and as a citizen? By such criteria we shall attempt to evaluate our results in the years to come.

If anyone tells you that such a person speaks ill of you, do not make excuse about what is said of you, but answer: "He was ignorant of my other faults, else he would not have mentioned these alone."—*Epictetus*

Enrolment in University Schools of Nursing

NEW classes will soon be registering in the various schools and departments of nursing across Canada. With no diminution in the call for qualified supervisors and clinical instructors in our hospitals, with public health nursing staff and supervisors in steady demand, and with the continuing development of the undergraduate program, a comparison of enrolment for 1946-47 and 1947-48 will provide an interesting background for the probable figures which should be available sometime after the universities open. The April, 1947, issue carried the report of enrolment for 1946-47. The 1947-48 figures are released herewith.

Thirteen Canadian universities include courses in nursing in their calendars. At the present time, McMaster and Saskatchewan provide only undergraduate courses and experience. Manitoba, Montreal, and McGill enrol only graduate nurses, the latter providing for work on both certificate and degree level. The remaining group of seven universities makes provision for both undergraduate and post-graduate work. The Institut Marguerite d'Youville in Montreal is included in the summary this year for the first time.

Table I shows the numbers of students registered in the various undergraduate years, including both those who are attending university and those who are having their theory and practical work in the affiliated hospitals. The number of veterans included in the various classes has fallen slightly from 23 in 1946-47 to 17. While the enrolment in degree courses has increased from 490 to 535, the list in special diploma courses available to undergraduates shows a decline from 192 to 98.

Again the greater number of post-graduate students have chosen the public health nursing electives though the total number is much lower than last year. The figures for veteran nursing sisters enrolled in the various post-graduate courses show a decided drop from 295 to 172. Table II gives a picture of the wide variety of courses that are available and the number of students in each. It is of interest to note the very large increase in the enrolment for courses in clinical supervision. The growing importance of this field of activity in our schools of nursing is indicated by the twelvefold enrolment for these courses.

TABLE I

UNDERGRADUATE NURSING STUDENTS

YEAR	Degree Course		Diploma Course	
	1946-47	1947-48	1946-47	1947-48
FIRST	170	161	62	35
SECOND	94	135	63	21
THIRD	86	104	59	42
FOURTH	66	84	8	—
FIFTH	74	51	—	—
Totals	490	535	192	98

TABLE II

Post-graduate Nursing Students

	Degree Courses				Certificate or Diploma Courses				Totals	
	First Year		Second Year		First Year		Second Year			
	1946-47	1947-48	1946-47	1947-48	1946-47	1947-48	1946-47	1947-48	1946-47	1947-48
A.....	2	3	13	9	11	5	6	1	32	18
B.....			11	11			5	15	16	26
C.....				2	4	4			4	6
D.....	1	1	14	17	42	36		1	57	55
E.....			11		10	5	3		24	5
F.....				11		28	6	33	6	72
G.....					50	8			50	8
H.....	6		19	20			4	2	29	22
I.....	9	6	11	4	77	55	6		103	65
J.....	34	10	19	11	294	188			347	209
K.....		10		15	14	43			14	68
L.....	9	3		59				22	9	84
Totals.....	61	33	98	159	502	372	30	74	691	638

A. Administration in schools of nursing. B. Administration in hospitals. C. Administration and supervision in public health nursing. D. Nursing education (general). E. Nursing education (advanced). F. Clinical supervision (hospitals). G. Supervision (special fields). H. Teaching in schools of nursing. I. Supervision in schools of nursing. J. Public health nursing (general). K. Public health nursing (advanced). L. Other courses (not specified).

A New Premature Nursery

SISTER DAMIAN

DECEMBER 29, 1946, is an important date in the annals of St. Paul's Hospital, Vancouver, for it marked the opening of its premature nursery, the first of its kind on the coast, and one of the most outstanding in the west. The nursery had just been blessed when its first occupant was admitted. Since then, many babies, varying in weight from one and one-half to five pounds, and from two weeks to two two months premature, have had the benefits of everything that modern infant care can offer the premature infant.

Sister Florence Mary, who is supervisor of the maternity floor, drew on her wide experience with babies from Portland to Anchorage to plan the premature nursery. The room is finished in soft rose and ivory tones. Venetian blinds at the two hermetically sealed windows give a homey appearance. Probably the first thing a visitor notices on entering is the system of germicidal lights. These are eight in number: one above the entrance door, one near the floor, another at the viewing window, three in the babies' section over the cribs, one near the nurses' sink, and the last one near the floor at the door leading into the infant's room. The lights render the air sterile, thus reducing to a minimum the danger of upper respiratory infections to which infants of this age are so susceptible. Indirect lighting prevents eye strain.

Air-conditioning is installed, hence changeable weather does not interfere with the ventilation of the room. The temperature is thermostatically controlled at 85 to 90° F., so the infants do not require extra covering which would cause discomfort. A humidifier keeps the humidity constantly at 65 per cent.

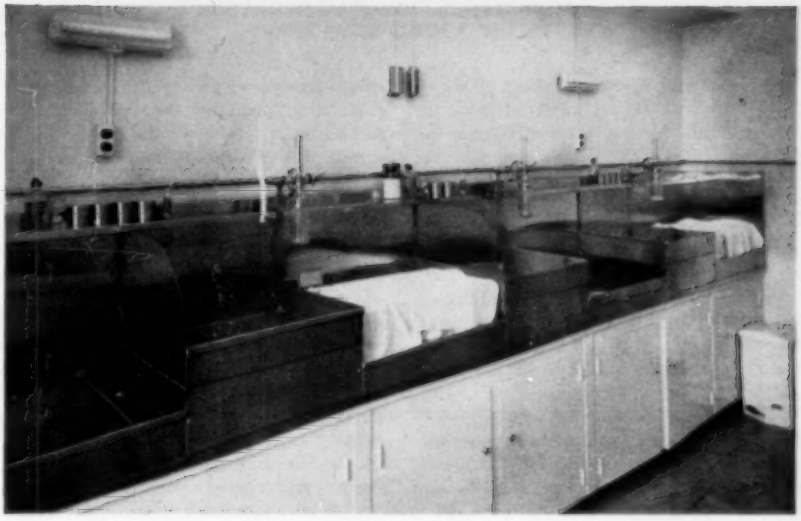
The nursery, measuring fourteen feet wide by twelve feet deep, is divided into two sections by a viewing glass, and only the graduate nurse in charge of the infants is allowed to enter the nursery proper. This section contains four steam-heated cubicles of monel metal and glass which receive the bassinets, though five can be accommodated should there be need. Each cubicle is actually a separate unit, composed of bassinet and an elevated bathing-tray on which the baby receives his daily oil bath, or bi-weekly soap and water bath. If the baby is too weak to be moved, this treatment is given in his bed with as little disturbance as possible.

An oxygen outlet with humidifier is provided at each cubicle, while individual meters allow oxygen flow to be regulated according to the baby's need. The main supply is a large oxygen tank in a special cupboard near the door. When a refill is needed, the orderly simply changes the large tank, without having to come near the babies. Sufficient concentration of oxygen can be provided simultaneously for all four cubicles, with the use of a plastic tent where this is indicated.

Directly beneath each cubicle is a wardrobe cupboard containing all the clothes the infant may require. Individual containers of baby oil, talc, thermometers, etc., are kept on a ledge above the cribs. Sliding racks on this ledge are designed to hold the interstitial drip flasks. It has been found that the infants suffer less discomfort, and have fewer complications when the interstitial is administered bilaterally at the rate of 60 to 80 drops per minute by interstitial drip, than when the fluid is forced in with a syringe at the same rate of speed. The subscapular region is generally used. There is a resuscitator kept ready for use at all times. This, with a bench for the nurse, and a hand-sink for her use, completes the furnishing of the babies' section.

The partition of the nursery is composed of the upper viewing glass, the oxygen supply tank cupboard, a series

Sister Damian is on the staff of St. Paul's Hospital, Vancouver, B.C.



Premature superheated nursery, St. Paul's Hospital, Vancouver.

of four two-way bins to receive the soiled clothes, and finally a door connecting the two parts of the room. The bins have a push-door on the nurse's side, through which she deposits soiled clothes into the laundry bags hung open to receive them. The laundry is collected through a door on the entrance side by a ward aide. The tops of the bins form the doctor's examining table. A glass sliding door, incorporated into the viewing window, is opened by the attending nurse when the doctor has donned mask and gown prior to the examination. Thus it is seen that only the nurse in charge enters the nursery proper. In this way, sources of infection are reduced to a minimum.

The infants all receive breast milk, at least during the first few crucial days, but occasionally a formula of lactic acid milk is later given. Indeed, most of the babies progress from eye-dropper and gavage to Brecht feeder, and finally to a real bottle of breast milk or, if possible, they are allowed to nurse. We may mention in passing that breast feeding has been the rule in the obstetrical department for the last year. It was adopted as a protective measure against Salmonella, which was so prevalent in the spring and summer of 1946, because breast-fed babies seemed to show less susceptibility to the infection, and those who contracted it showed greater resistance. Our obstetricians were very helpful in enforcing the new regulation; no doubt they felt amply rewarded when they found a definite decrease in feeding problems.

The work has not been in progress long enough to present imposing statistics but the value of it is being proven every day. Obstetricians of St. Paul's Hospital feel less uneasy now about a premature birth than they would have been earlier, and these are a few of the reasons:

1. The premature infant is placed in the superheated nursery where its body temperature is more easily maintained and stabilized.

2. Oxygen is administered routinely through the plastic head mask for the first twelve hours, conserving the infant's strength.

3. A graduate nurse, specially trained, is in constant attendance.

4. Outside contacts are limited to the three nurses — one on each shift. Even the doctor does not enter the nursery! There is, therefore, little danger of infection from others.

5. Even though the mother may not be able to nurse her baby, breast milk will be provided as long as there is need for it.

In the Good Old Days

(*The Canadian Nurse*, August, 1908)

"Discords in the prevailing harmony between the doctor and nurse are rather uncommon, usually the feeling being of the warmest, and the sympathy and good fellowship of the strongest, and it is indeed a happy feeling to the worn-out nurse to know that with the doctor's arrival her troubles will be over, at least for a time, and the point which she has been battling for so loyally upheld by him, and her rough path made smooth by the tactful words and happy manner of the attending physician."

"Let us remember that the Canadian Nurses' Association belongs to *each one of us*, not to our President *alone*, and it is our duty, as it ought to be our pleasure, to help and strengthen her hands in every way we can.

For instance, when a subject is put before us, it cannot be very pleasant for her, for us to sit still and look at one another. If the subject is for discussion, why not discuss it? Our opinion is asked for, why not give it? What matter if we are not quite sure of the subject. Now is the time to learn.

One thing is certain, it will help make our President's task a trifle easier, and she will feel encouraged when she sees us take a real live interest in our association, and do not sit like mummies or deaf mutes, and leave all the hard work in the hands of a few, while we enjoy the blessings."

Forty years ago! And nurses still go to meetings and just *sit!*

"At Yale the students' board costs $4.95 per week; at the University of Indiana it averages $1.85 for the same period . . . At the latter, one of their four-cent breakfasts consists of delicious apple sauce, bread and butter, rolled oats, baked potatoes, coffee with milk and sugar . . . when eggs are cheap they are substituted for baked potatoes."

"If your patient has plenty of flowers in the sick-room suggest to some friend to bring a few gold fish in a pretty bowl, instead of flowers. The fish are usually a source of interest and pleasure to both child and adult invalids."

The report of the first graduation exercises of the Brandon General Hospital on June 18, 1908, is included. An account of the closing exercises of the twenty-sixth graduating class of the Toronto General Hospital, and of several other schools, makes interesting reading as occasional familiar names crop up.

"It is not easy to define in a single phrase the subject commonly called ethics in such a manner as to meet with general acceptance. It is an abstract rather than a concrete subject, therefore a definition of the latter, such as chemistry by way of contrast, may help us to explain ethics. Chemistry is concerned with what is, has been, or will be: Ethics with what is good or what ought to be . . . If we make an examination into the general nature of ethics, we would consider the three chief factors concerned — faith, purity, and love . . . *Faith* — a clinging to moral and religious conviction . . . *purity* — an abstinence from all things unlawful and intemperate . . . *love* or self-sacrifice — love to God in the first place and, as a development, love to all mankind."

The following stanzas, extolling the value of the "apple a day," conclude an article on diet:

In these days of indigestion — of fever and congestion,
A new and pleasant remedy has lately come to light;
'Tis a cure all pure and simple, the very latest wrinkle,
Just eat a big round apple, and you'll be all right.

If you're feeling pessimistic, in a way that's realistic,
If everything is going wrong and things look black as night;
If you're ill in mind and body — do not take a drink of toddy,
Just eat a big round apple, and you'll be all right.

Take from the altar of the past the fire, not the ashes.—JEAN JAURES

STUDENT NURSES PAGE

Fractured Skull

KATHERINE DYCK

JANETTE is a healthy normal child, having been hospitalized previously only for the removal of her tonsils and adenoids and, in 1940, for shock from a fire. Her weight is one hundred pounds, her appetite is very good, and she has regular bowel movements. Her skin is clear, a healthy color, and good texture.

Janette, being twelve years old, is entering the age of adolescence and this was quite noticeable in many ways. In adolescence rapid physical and intellectual growth is taking place and some instability in emotional development is apparent. Janette is very devoted to her parents and they to her. Perhaps she clings to them a bit too much for her age, because she found it extremely difficult the first week to be separated from them. She is the youngest member of the family, her two sisters being away from home. Perhaps this is the reason why she is just a bit spoiled and self-centred. She obeyed very well though, and her manners showed good guidance on the part of her parents.

Her health habits, such as cleanliness, care of teeth, cleaning and filing of nails, combing hair, etc., were well established.

Her mental attitude was that of a normal child. Her interests were many and varied, and the accident left no ill effects on her mental status and memory.

Symptoms of skull fracture: History of fall — While getting off the bus, she was struck by a passing truck and thrown a short distance, landing on a hard, surfaced road. Janette's mother stated that she had appeared to be unconscious for a very short time before being taken to the hospital. She was never unconscious during her stay in the hospital, but she was very listless, drowsy, and indifferent to her surroundings for the first few days.

Janette complained of pain in her head, especially at the site of fracture. We could not comb her hair for a week because it intensified the pain too much. She did not complain of any pain in other parts of her body. Swelling of the area could not be seen because of the hair, but tenderness was definitely present. There was no deformity that we could see. Except for the fact that she did not move her head about much for the first few days, there was no loss of function. There was no discoloration that we could see at the site of fracture. On other parts of her body she had dark blue bruises.

Janette showed some of the signs and symptoms of a mild case of shock. Her face was quite pale and had a slightly anxious expression. She was inattentive to her environment for quite some time, but her pulse, respirations, temperature, and blood pressure were not typical of shock.

During the first night and day, Janette was nauseated and vomited quite frequently in large quantities, the emesis being a clear greenish-yellow color. She was unable to retain her first few doses of sulfa, bring-

Miss Dyck is a student nurse at the Saskatoon City Hospital.

ing it up almost immediately after swallowing. The following day these gastric symptoms vanished.

The shock of the accident and the change of environment helped to bring about a mild case of general malaise which lasted about ten days. Because it was very mild, it did not postpone her recovery. She had a slight rise in temperature the first week, probably due to excitement, and pain in the injured area. This could also be from stimulation of brain.

None of the complications which may arise from a skull fracture appeared in this case.

Physical findings: Janette's right eye was black, swollen, and she was unable to open it when she arrived in hospital. She also had numerous bruises on her chin, nose, knees, elbows, and wrists but these had little significance as far as her recovery was concerned. The bruises disappeared gradually, and she was able to open her eye the next day. At discharge, none of these symptoms was present.

Temperature, pulse, and respirations were taken q.4.h. They were slightly above normal for several days, probably due to the excitement and pain which accompanies fractures. If the temperature had become subnormal, pulse slower, slow respirations, with higher blood pressure, increased intracranial pressure would be indicated. As the patient recovers, there is a return to normal. If the patient dies from increased intracranial pressure, his clinical sheet would show, instead of a return to normal, an increased temperature, faster pulse, respirations increasing, becoming Cheyne-Stokes in character, and falling blood pressure. In head injuries it is very important to keep a close check on the blood pressure because a sudden rise or fall indicates complications. Janette's blood pressure decreased from 120/90 to 100/58 but the next day it returned to normal 128/98, and remained constant, with only very slight variations, for the remainder of her stay in hospital. This and her x-rays showed quite clearly that the fracture was not depressed, which accounts for her speedy recovery.

The *laboratory findings* on the cerebral spinal fluid showed total protein — 111 mgm. per 100 cc., normal, 15-40 mgm. per 100 cc.; cell count — R.B.C. 41,600 per cm., normal, 0-10 per cm.; macroscopic appearance — bloody; normal, clear. This change from the normal is not very great, and was probably due to some hemorrhage, which would account for the bloody macroscopic appearance, also the presence of R.B.C. and an extra amount of protein. Her urinalysis shows no particular deviations from the normal.

Description of the condition: Fracture of the skull is usually important, not of itself, but because of the amount of injury done to the brain, and the possibility of associated intracranial hemorrhage. Fractures of the skull may be divided into four groups: (a) simple; (b) depressed; (c) fractures compounded by scalp laceration; (d) fractures compounded by injury of paranasal sinuses or mastoid air cells.

A simple fracture would cause trouble only if it injured or tore the middle meningeal artery which runs just beneath the bone. A depressed fracture makes laceration of the brain likely and, therefore, calls for the earliest possible surgical intervention. There is great danger of meningitis in the c. and d. fractures and steps should be taken immediately to offset this risk.

Skull fractures may also be classified according to signs and symptoms. These would be:

Concussion: Loss of consciousness from a few minutes to several hours; laceration of scalp or fracture of skull; temporary paralysis of the brain — giddiness to complete senselessness. In the average case, the patient is unconscious, cold, respirations slow, pulse rapid and weak, temperature subnormal.

Cerebral irritation: Several days after injury the patient becomes restless, irrational, disoriented, and confused; indifferent to environment; delusions, illusions, hallucinations present; photophobia present.

Cerebral compression, laceration, and gross damage to brain: Unconsciousness, delirium, coma; bleeding and discharge of cerebrospinal fluid from nose and ears; dilatation of pupils—

indicates pressure; paralysis may develop; signs of impending death — slow pulse, high pulse pressure, rise in temperature, difficult respirations, and sudden fixed dilatations of pupils.

Doctor's orders: Immediate — Nothing by mouth because of the gastric disturbances. Dr. A feared there might be some injury to the internal organs. Extra blankets were added to give her greater warmth because she was suffering from shock. As a prophylactic treatment, 500 cc. blood plasma were given slowly. This would guard against severe shock. It would also be very important if hemorrhage should set in, either at the site of fracture or in the internal organs. Penicillin 20,000 units q.3.h. with novacaine was ordered to stop any infection from increasing and spreading. Novacaine is added to the penicillin to lessen the pain of administering it.

The second day sulfadiazine gr. 15 with soda bicarb. gr. 10 q.3.h. was ordered in addition to the penicillin. The sulfa drugs, being bacteriostatic, are given for the same reason as penicillin. Soda bicarbonate is given also because it helps to decrease the toxicity of the sulfa drugs.

The doctor ordered her to have sips of water and ice chips to suck; light, salt-free neurological diet; small pillow. The latter was given mostly to satisfy the patient, because she was asking for it constantly. She was given ice chips to suck to help overcome the dry feeling in her mouth without increasing her fluid intake too much. Because there is possibility of trauma to the brain in a skull fracture, edema of the brain could occur and thus increase the brain volume. In order to keep the degree of edema as low as possible, fluids are restricted, and salt, because of its osmotic power of retaining fluid in the tissues, would be prohibited. Janette was very hungry the first day and was given her first meal at supper time. She was able to retain it, and her diet was practically back to normal at discharge.

By the fifth day there were no signs of any infection, her temperature was not very high so the doctor did not think it was necessary to continue the penicillin. The next day the sulfa was discontinued also.

At the end of the first week a test of the visual fields was done to determine if the fracture had injured the optic nerve. Her visual field reading was normal.

All head injury cases are kept in bed for at least two weeks, even if they may feel perfectly well. The quieter the patient remains, the less scar tissue will be formed around the fracture, and this would be a very important factor in a skull fracture. At the end of this time, the doctor felt it was safe to let her go home where she would have to take things easy for some time yet.

Nursing care, problems, and procedures: Each case of skull fracture is treated as an individual problem because you can never be certain when and what kind of complications will set in. Therefore in the nursing care it is of utmost importance to keep a continuous accurate recording of the following:

Pulse: At first it should be recorded every 20-30 minutes, later q.4.h. A slowing pulse down to 60 or even 40 is a reliable sign of acute increased intracranial pressure.

Blood pressure: Systolic and diastolic — These must be very accurate and it is important to know that the diastolic pressure is not read at the disappearance of the sound but at the change from "the clear, sharp, loud, snapping sound to one of a mere muffled quality." A rising systolic and diastolic blood pressure should be reported immediately.

Respirations: The rate, regularity, and quality are of paramount importance. You must be sure that the change (this may be stertorous, shallow, irregular, etc.) is not due to improper posturing of the patient.

Temperature should always be taken rectally because sometimes these patients may be unconscious yet appear conscious and, therefore, cannot be held responsible for their actions. Usually the temperature is normal or subnormal. An increased temperature indicates intracranial hemorrhage, or a complication called neurogenic hyperthermia (due to injury of the temperature regulating centre).

Level of consciousness, increasing drowsiness, stupor, and approaching coma are serious signs and should be reported immediately.

Dilatation of one pupil usually indicates intracranial hemorrhage.

Posture: The patient should be kept flat in bed for approximately two weeks, depending on the extent of injury. Janette was kept in bed for this length of time. It was hard to amuse her in this position, because she was not allowed to read and she was too old to play with toys. Whenever we had some spare time we would read to her. She also received many flowers and cards from family and friends. These played a part in her recovery.

Accurate administration of drugs is always important. Penicillin, given intramuscularly, must be given carefully to avoid any infection from the injections.

Complete bed rest would include a complete bath every morning, feeding the patient, and helping her in every way, so that she will not have to exert herself. The first few days this was not difficult to carry out, because Janette was indifferent, but after the first week she started doing things for herself. Because no complications were setting in, this was perfectly all right. One nursing problem that entered the picture, in caring for her physical needs, was the combing of her hair. Janette's hair was very fine, long, and matted with dry blood. Because we were unable to comb it the first few days, it became more and more matted and tangled. After five days, she let us comb her hair, which took approximately half a day to finish. We used hydrogen peroxide with quite a bit of success to loosen the dried blood in her hair.

The chief *nursing problem* was to keep Janette amused and keep her thoughts away from herself while she was in bed and even when she was allowed to get up. After the first week, other children came and talked to her which helped a great deal. Another girl in the same age group as Janette was moved into the cubicle next to hers, and the two spent many happy hours together.

When Janette was discharged she claimed she remembered very little of the first week of her stay in hospital. The bruises and her black swollen eye had practically cleared up after ten days. The first week she was fed, but after this she started to feed herself. Her appetite increased daily. She began to show which foods she preferred and her interest in her meals increased, so that when she left the hospital she had the appetite and interest of a normal child of that age. In the plans for her convalescence, the most important point was rest, both physical and mental. Lots of fresh air, sunshine, and a nourishing diet would have a prominent place in her convalescent days and, of course, throughout the following years as Janette is still in the growing age. Unless an excess amount of scar tissue develops around the site of fracture and thus causes pressure on her brain, her prognosis should be good. If she should develop frequent headaches, dizziness, or even epileptic seizures, she should be taken to a physician immediately, as these may easily be traced back to the result of her skull fracture.

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℞ *Chuckles* P.R.N.

The first president of the Canadian Nurses' Association was Fabiola.

Patient in plaster cast: "Nurse, you will have to cataract me."

The dorsal posterior means the front of the back end.

The treatment of chololiths: "Open the gall bladder and capture some stones."

Leukocytosis means inflammation of the leukocytes.

On an anatomy paper: The liver is situated in front of the heart and below the stomach.

All discharges from the naso-pharyngeal tract should be carefully cooked before being thrown away.

The os calcis may be the mouth or a bone in the foot.

Anti-bacterial serum is used for snake-bites.

An antigen is a substance which speeds up the action of another substance when given with it.

The Widal test is based on the bacteriological principle that bacteria must be grown in pure culture.

The Rockefeller Foundation Review

ONE of the finest presentations of the role of medical and kindred personnel in assisting to solve present-day, world-wide problems of well-being, both physical and mental, will be found in the Review for 1947 of the activities of the Rockefeller Foundation. Raymond B. Fosdick, president of the Foundation, states:

The challenge of today's crisis is the most commanding which Western society has ever faced. We have always known that knowledge was a perilous possession, because it could equally well work in the wrong direction: but the knowledge that has been placed in the hands of this age is so supremely capable of misuse — and misuse could so easily reduce the hopes and monuments of men to drifting dust — that the impact of the challenge finds us confused, uncertain, and fearful.

Dr. Fosdick points out that the first universal reaction to this form of dread is to use physical force to combat it — military conflict. The inevitable result has always been wreckage and retrogression. He says, "Unless we can rise to greatness and lift our answer to an intellectual and ethical plane, our fate will be the fate . . . of the nations that preceded us in history." Mankind is very prone to believe that "the good life" is dependent on our standards of living, our recognition of the findings of scientific research, our military ascendancy.

The dynamic tensions of our society can be relieved only by moral and social wisdom.

Our age . . . can be a great age, like other ages that have been born out of fear and challenge. Its greatness, however, if achieved, will consist in its search for an enlightened humanism and for rational and ethical values that will rise above our times . . .

The world of the future . . . will be a world of diversity, held together by a conception of common interests. It will be a world in which many political faiths and economic creeds are tolerated and widely differing points of view fertilize each other for the common good.

Our challenge in this generation is to discover the common interests, the terrain of possible collaboration, the over-lapping areas of curiosity and sympathy, of aspiration and mutual advantage, that bind the human race together regardless of ideologies or boundary lines . . .

In terms of human suffering the world is truly and tragically one world.

The people are dominated by a passionate hope for peace, security, and a better life. They seek a world in which men may grow in strength and dignity.

We must push toward the ultimate goal of world unity with iron determination and fanatical patience. We must believe in it against all discouragement, against all failures, against all betrayals. There is indeed nothing else we can do.

In describing the work sponsored by the Foundation in various parts of the world, the report stresses the unfortunate results which follow the isolation of scientists and scholars by ideological patterns. "An intellectual fog, if it becomes dense and general, can be more baffling and stifling than any tangible barrier." "Isolationism is a blight which undermines the vitality of everything it seeks to preserve." The problems presented in Germany and China receive comment and review. In discussing the wider horizons of public health, the writer states:

It is inconceivable that complete preventive, diagnostic, and curative services should, for any individuals or groups, be determined by financial status rather than by actual need.

For nearly thirty-five years, the Foundation has evidenced its interest in nursing education by investing vast sums of money for its advancement in many countries of the world. The following quotation from the report will be of especial interest to Canadian nurses:

In the early thirties aid was given to the school of nursing of the University of Toronto to establish a basic professional program in the preparation of students for community nursing service. Kathleen Russell's leadership, scholarly ability, and insight into the community's nursing needs have produced an outstanding research program, and Toronto is one of the peaks of nursing training in the world.

The National Bureau of Economic Research "seeks to lay a more adequate foundation for objective thinking and research in economics." One interesting special grant went to The Royal Institute of International Affairs to further the work and writings of Professor Arthur J. Toynbee. In advancing the cause of the "humanities," opportunity has been provided for younger men and women "to study the life and languages of the Far East, the Near East, and the Slavic world." To date some eighty students have been assisted to develop the skills which will permit them to "qualify as interpreters of these regions."

To help in extending the frontiers of the mind in time as well as in space — this is the framework of the Foundation's program.

Nursing in Korea

Korea is so much in the news these days that I am sure you would like to hear something pertaining to nursing here. I have been wanting to write to *The Canadian Nurse* ever since I returned here, but the opportunity did not seem to present itself.

As you know, I spent the years from 1927 to 1940 in Hamheung, which is in North Korea, now occupied by the Russians. In Hamheung, we had a flourishing training school and there were others scattered all over Korea. The country was then under the Japanese regime and the government schools of nursing were all run on the Japanese system, that is, two years' training for nurses after which they were given a licence to practise. If she graduated from a non-government school the nurse was allowed to write an examination for the licence, by bringing proof that she had spent at least twelve months in a hospital. From this you can see how easy it was for many who knew nothing about actual nursing to obtain a licence. The eight or ten schools which were run by the various missions gave a thorough three years' training but, as only one of these schools, Severance School of Nursing, was recognized by the government, the graduates were required to write the examination. They had very little difficulty in passing until the time when the Japanese were sponsoring the *National Spirit* to such an extent that anything western was not acceptable to them. Then the girls from mission schools were failed for no other reason.

During the war, after the missionaries left, every effort was made to remove all traces of western influence from every department of life. How well they succeeded I have been discovering. All equipment that could be used to help the war effort was taken from the hospitals and little or no repairs have been put on them for eight years. Nurses were told that they were there not to wait on patients but *to wait on doctors*! Consequently the nursing profession in Korea had deteriorated greatly.

Now we find that the patient is admitted to a hospital and is expected to bring his own bedding, food, and clothing, as well as his own practical nurse to wait on him. The graduate nurse, so called, is in the clinic looking after the doctor. If she has any time she will take the patient's temperature and bring his medicine bottle and place it on the table. Whether he takes it all at once or as directed is no concern of hers, apparently. We find little charcoal stoves all over the halls where the patients' friends are cooking meals for them at any hour of the day or night.

Those nurses who did not agree to work in this fashion disappeared into the country rather than stay in hospitals under these conditions. So, when the American Army of Occupation came to the South, their nursing officers reported that there had been no nursing done in Korea. Gradually they began to find a nurse here and one there and all that they found who had any knowledge of nursing were those who had been trained in the mission schools.

The Korean Interim Government of the South, backed by the U.S. Military Authorities, has now set up a Department of Public Health and Welfare with a Korean head and an American adviser. Under this department, or perhaps I should say, in the department, is a Bureau of Nursing Affairs. The Korean

head of this is a girl who was trained in Severance School of Nursing after which she was sent to Australia for futher study. She has an American adviser also. This bureau now has charge of all affairs pertaining to nursing, such as supervision of nursing schools, curricula, entrance standards, licensing, and so forth. They have established a licensing agency for midwives and nurses. Each midwife is to have had at least two and a half years of general training before being given her midwife's licence. This bureau is also supervising the translation and printing of nurses' textbooks. These are sorely needed as are textbooks for any department of education. My mission has given me permission to help with the work of translation as I am one of about four western nurses now in Korea with a knowledge of the Korean language.

The Nurses Association of Korea has been reorganized under the leadership of Mrs. Hong who is the head of the Bureau of Nursing Affairs. In the old days we had worked up to being an Associate Member of the I.C.N. In 1937 we joined as a subsidiary member of Japan. Now the Korean nurses are very anxious to become a member country in their own right, which is a very worthy ambition. I hope it will be realized before too many years have passed. They are at least getting on their feet.

If the political situation of Korea can be satisfactorily settled, I can see no reason why nursing should not attain to the high standards which will qualify them to enter the I.C.N. In the meantime there are many handicaps such as inflation which makes it almost impossible to buy things necessary for the running of the hospital or training school — lack of water, fuel, equipment, necessary repairs to physical plants.

The challenge to us who are here to help is a large one and we have great hope for the future. We see many difficulties ahead, but with perseverance and all working together there is no doubt that the N.A.K. will one day hold up its head with pride.

To any nurse in Canada who is looking for a job that is anything but monotonous and will tax all her powers and ingenuity, I say, "Come on over here and help us." If there are any who would like to help the Korean nurses, but would not think of coming here, they can help by sending their old uniforms which are now too short for them. We cannot get uniform material and the nurses are almost desperate for something to wear. Such uniforms should be sent to me at the address: *The Social Evangelistic Centre, 194 In Sa Dong, Seoul, Korea*. Parcels of up to eleven pounds will be accepted by the post office. Each parcel should be marked "For relief." Thank you, Canadian nurses!

— ADA SANDELL

National Immunization Week

Canada's sixth National Immunization Week will be observed this year during the week beginning September 12, sponsored by the Health League of Canada in co-operation with Dominion, provincial, and municipal health departments throughout Canada. The week is devoted to the intensifying of the all-year efforts of health departments and the Health League of Canada to call to public attention the need for protecting children against diphtheria, smallpox, and whooping cough by immunization.

These diseases are largely preventable by adequate immunization. They attack all ages but babies and little children are easy victims of these contagious diseases.

Medical science has discovered and produced immunizing agents — such as diphtheria toxoid to prevent diphtheria, whooping cough vaccine to prevent whooping cough, and smallpox vaccine to prevent smallpox. Vaccination has practically eliminated smallpox in Canada and diphtheria toxoid can do the same with diphtheria if it is given a chance. Whooping cough, which kills more young children than all the other so-called children's diseases combined, can be prevented by use of whooping cough vaccine.

However, despite the availability of these protective measures these diseases still menace the health of Canada's population. The accompanying comparative chart shows

		1947	1946	1945	1944	1943
Diphtheria	Cases	1,550	2,535	2,786	3,211	2,804
	Deaths	139	229	270	311	287
Whooping Cough	Cases	10,327	7,676	12,192	13,382	19,082
	Deaths	221	226	457	333	416
Scarlet Fever	Cases	7,492	9,308	11,982	20,945	18,639
	Deaths	41	58	79	114	100
Poliomyelitis	Cases	..	2,527	384	721	327
	Deaths	90	177	24	39	26

cases and deaths from the diseases concerned during the last five years.

Scientists are attempting to develop a preventive for poliomyelitis, but it is tragic that Canadians are not co-operating with the medical authorities to the fullest degree in accepting the available means to wipe out or reduce diseases which are preventable.

It is pointed out that thousands of lives have been saved by use of toxoid in the prevention of diphtheria — yet, last year there were 139 deaths from diphtheria in Canada as compared to 90 deaths from poliomyelitis. Whooping cough, which also can be prevented, took the lives of 221 Canadians in 1947.

All children should be protected against diphtheria, smallpox, and whooping cough during the first year of life and provided with "re-inforcement" of their immunity as may be found necessary as they enter school and during their school life. With such a program in effect these diseases could be practically eliminated.

In order to make such a program effective we need the co-operation of parents, nurses, teachers, clergymen, and citizens generally in seeing that every Canadian youngster is protected with the inexpensive, efficient, and painless protection offered by doctors and public health officials.

Diaper Rash

Ammonia dermatitis is a common condition in infancy. It appears in waves of from ten to fourteen days. Most cases can be cured by rubbing into the diaper at bedtime four to six teaspoonsful of boric acid powder. Enough boric acid powder must be used to eliminate the odor of ammonia in the morning. The dermatitis can then be cured by exposing the buttocks to the air for one half hour morning and afternoon. The application of boric acid ointment at night will protect the buttocks from the irritating urine. A fresh diaper should be put on at the parents' bedtime. — *Medical Times*

The Old Oil

The secret of giving cod liver oil to a child is the same as starting on any other new food — using the right psychology, nutritionists believe. If the mother approaches smilingly and shows the baby she expects him to take the oil, the chances are he will reflect the mother's attitude and take the oil without protest.

It is now known that it is a mistake to wait until the child is several years old to decide if he needs cod liver oil. He should have the oil every day. It is best not to take a chance.

Insecticidal Solutions

Various insecticidal dusts and sprays have proven highly effective in the householder's war against insects and other pests but such agents include potentially dangerous chemicals, including lead arsenate, basic copper arsenate, paris green, cyanide and fluoride compounds, sulphur and nicotine.

The poisonous effect of each of these insecticides varies according to the nature of its chemical composition but prolonged contact with most of them may have harmful effects. Care should, therefore, be taken when handling all such toxic materials.

Book Reviews

All About Feeding Children, by Milton J. E. Senn, M.D. and Phyllis Krafft Newill. 269 pages. Published by Doubleday Publishers, 105 Bond St., Toronto 2. 1946. Price $2.50.

Mothers are always anxious for information about how they can best look after their children. There are many books on the various aspects of infant and child care but here is one that is devoted exclusively to "complete and definite instructions on exactly how to cook for children." Here will be found not only "how" but also "what" may be included in the diet at various ages. Perhaps even more helpful will be the directions of the authors on "the technique of offering foods so that baby will eat them willingly and with enjoyment." The authors state that they have "attempted to allay the fear, resulting from a misinterpretation of sound scientific facts, that certain foods *must* be consumed daily, in stipulated quantities, or dire consequences will ensue."

Various studies have demonstrated that, despite the quantities of food available in Canada, the general nutrition of our people is below the desirable level. The authors account for this fact in this way: "By the end of the second year of life most youngsters no longer require specially prepared foods, and a mother's vigilance over the selection of their menus is apt to start tapering off. As a result, a regrettably high percentage of children reach school age suffering from malnutrition in various degrees of severity." Public health nurses will, therefore, find much valuable information in this book which can and should be passed on to the mothers at the child health centres and in home visits. Nurses in hospitals will find it valuable also.

Nursing, by Lulu K. Wolf, R.N., B.S., M.P.H. 534 pages. Published by D. Appleton-Century Co. Inc., New York. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 1947. Illustrated. Price $4.00.

Reviewed by Eleanor Graham, Health Instructor, Metropolitan School of Nursing, Windsor, Ont.

"The fundamental theme of the book is that every nurse — student or graduate — who assumes the care of a patient, has an obligation to him, his family, and the community in which he lives, to conserve his health and prevent further illness. Not only must the nurse care for the patient during illness and help him get well, but she must care for him in such a way that he will stay well after he gets well."

So states the author in her preface, and it is remarkable how this theme is woven into every section of the text without the continued emphasis on the social aspects of nursing becoming at any time monotonous through repetition. Written primarily for the young student and based on the premise that she must first learn the full meaning of health and healthful living, Part I is devoted to the origin, development, and present trends in nursing and the status of nursing today, followed by an overall picture of the nation's health problems and the functions of the nurse in the broad health program and as a member of her profession.

Part II centres around the hospital, the patient's room, and the patient as an individual. Following a description of the hospital as a community health agency, there is an excellent chapter on the admission of the patient, emphasizing the importance of establishing rapport and showing how to reassure him through displaying an interest in him as an individual and explaining the hospital routine and regulations.

The final part is devoted to the various activities carried out by the nurse in the care of the patient with emphasis, in every phase of the care, upon the importance of recognizing and ministering to the physical, emotional, and social needs of each patient as an individual. The function of the nurse as an example and a teacher of health is brought in skilfully all the way through the text. The last chapter deals with the provision for the patient's needs on discharge from hospital. There is a comprehensive discussion of the responsibility of the nurse to teach the patient or a member of the family how to give the necessary care, but there is no mention of the assistance available to the patient through various community agencies. This

omission is a serious one. In fact, nowhere in the text is anything said about an affiliation with a public health nursing agency, or the importance of the nurse understanding the functions of local health and welfare agencies so that she would be able to recognize her responsibility to see that a patient is referred to the agency best able to provide necessary follow-up care.

However, except for this one point, this book is outstanding in its interpretation of nursing in its fullest sense. There are carefully selected references and the illustrations are excellent. It is equally valuable for the student, the instructor, the staff nurse, and the ward supervisor, and it might well be adopted as a text in every school of nursing.

Study Guide in Medical Nursing, designed for correlation with study courses in schools of nursing, by Janet Correll Reinhard, B.S., R.N. 342 pages. Published by F. A. Davis Co., Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 1947. Price $3.25.

Reviewed by Helene Lamont, Medical Supervisor, Royal Victoria Hospital, Montreal.

This manual is designed for correlation with study courses in schools of nursing and will serve as a guide in learning the practical side of medical nursing. The method of exposition is built around typical case studies of patients, with history from admission to discharge.

All medical conditions are not included but the diseases treated are those with which every student should be familiar. Wherever possible the author has made an effort to correlate all phases of the patient's illness with the study of specific drugs, nursing procedures, diet, and tests.

A list of questions at the end of each chapter should stimulate the student to further study of the text and reference material. This manual should be an excellent guide for the student in her study of medical nursing.

A Handbook for Nursery Nurses, by A. B. Meering, S.R.N. 509 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1947. Illustrated. Price $4.40.

Reviewed by Elizabeth Copeland, formerly Supervisor, Health Unit 3, Metropolitan Health Committee, Vancouver.

This book was written as a textbook for English nursery nurses-in-training. It deals with all aspects of caring for children in sickness and health in a very simple, practical way.

The chapters on anatomy and physiology, although brief, are authentic. One wonders why the section on the reproductive system does not include the male reproductive organs.

In most instances the information agrees with the principles of preventive measures as taught in Canada. However, the differences such as public health services, immunization, and the time for introducing solid foods, are marked enough to make it inadvisable to suggest this as a textbook for use in Canada, although it could be recommended as a reference book.

The entire book has an excellent positive approach to child training and management. The section on growth is particularly good, placing the emphasis on building a sound foundation for physical, mental, and emotional development during childhood to ensure a happier, healthier adulthood.

Mrs. Meering stresses the need for planning a good routine which is flexible enough to meet the child's needs and at the same time fits into the family requirements.

A well illustrated, readable, and instructive book.

Campus Shadows, by Harold W. Trott, M.D., C.M. 371 pages. Published by Crosset & Williams, Hemlock, N.Y. 1946. Price (in U.S.A.) $2.75.

Feeling discouraged, blue, at odds with the world? No! We don't recommend any of the nationally advertised pill-remedies, but we do earnestly suggest you read "Campus Shadows."

Autobiographical, this is the account of Dr. Trott's story of his struggle to obtain his doctor's degree. Important as this is in its own right, the essence of the book is the sheer tenacity and singleness of purpose, imbued in Dr. Trott, that resulted in his overcoming misfortune to achieve his goal.

Read his courageous, almost hopeless fight to survive Landry's paralysis with which he was stricken at the end of his first year in medical school at McGill University. This miraculous recovery took place at the Royal Victoria Hospital in Montreal. (We warrant you will forget that your back and feet hurt from constant attention to that fussy patient in Room 132.) His recovery was slow and

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tedious. Despite his crippled condition, however, he enrolled at the University of Western Ontario to further his degree, finally returning to McGill and graduation in the early 1920's.

Disillusioned about the pill-hypnotized public he seems doomed to serve, he nevertheless finds his niche at Hemlock, New York.

Crisply and simply told, this chronicle of college days and after-graduation experience, shot through with tragedy and humor, will enthral you.

The Story of St. Thomas's (1106-1947), by Charles Graves. 72 pages. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 1947. Illustrated, including color plates. Price (tentative) $3.00.

A fascinating story of hundreds of years of service to humanity is enrolled in this small history. Established originally as an infirmary for the sick poor of London, the hospital took its name at the canonization of St. Thomas à Becket. Medical practice in the days before the dissolution of the monasteries was in the hands of the monks. "In those days priests were not allowed to shed blood . . . and it was necessary, in consequence, for all surgery to be handed over to a subordinate not in holy orders. Which is the reason why, even today, the physician takes precedence of the surgeon."

Though no records of patients were kept during the first few hundred years, much interesting source material is included in the pages. The Standing Orders incorporated in the minutes of the governing board in 1699 are amusing in the light of the present day. The modern problem of clearing hospital beds finds its counterpart in: "No patient is to be kept to whom no physic or chirurgery is prescribed."

Illustrious personages associated with the hospital are noted. None brought greater lustre to its annals than Florence Nightingale. Here is the story of how, under her guiding influence, St. Thomas's became the cradle of modern nursing. Miss Nightingale welcomed the rapid rise of other schools of nursing most of which applied for graduates from St. Thomas's to initiate the new program. The medical school developed less rapidly.

The "catastrophe of war" is graphically described. The hospital suffered widespread destruction from enemy action. This was not the first time the hospital had been destroyed so it is not surprising that with characteristic vigor new plans presage a bigger and larger St. Thomas's.

This well-written account has deep historical interest. It has humor and pathos. Every nurse would enjoy reading it.

Manuel de Diététique, principes et techniques, par Soeur Barcelo, r.h. 382 pages. Hôtel-Dieu, 109 ouest, avenue des Pins, Montréal, 18. 1947. Prix $2.50.

Compte rendu par Suzanne Giroux, Visiteuse officielle des Ecoles d'Infirmières, l'Association des Infirmières de la Province de Québec.

L'auteur est bien connu dans le monde hospitalier, infirmières, et diététistes de l'Hôtel-Dieu, Montréal. Elle est la première canadienne-française à être membre de l'Association des Diététistes des Etats-Unis et du Canada.

Ce livre écrit spécialement pour les élèves infirmières se divise en deux parties. La première, comprenant les six premiers chapitres, traite de toutes les connaissances que doit avoir l'élève sur les besoins de l'organisme, la valeur des aliments, leur classification, la préparation des aliments. La deuxième partie traite de l'application de ces connaissances dans le soin des malades — la diétothérapie.

Les régimes prescrits par les médecins peuvent varier il est vrai, suivant les écoles; néanmoins l'élève trouvera toujours l'application rationnelle des connaissances acquises dans la première partie de ce livre.

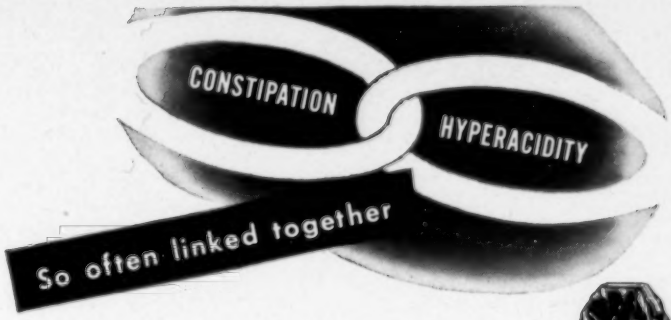
L'habitude de l'enseignement aux infirmières se reconnait facilement chez l'auteur; ce rappel, par exemple, au chapitre de la diétothérapie, de la physiologie, de la pathologie, des agents thérapeutiques autre que la diète, conseils d'hygiène, etc.

Ce livre est recommandé non seulement aux élèves de nos écoles d'infirmières, mais aussi aux infirmières du service privé, aux infirmières hygiénistes, comme livre de références, il leur rendra de nombreux services.

L'Armoire aux Remèdes, par le docteur G. A. Séguin. 210 pages. Imprimé par Les Editions Lumen, 8125 blvd St-Laurent, Montréal 14. 1947. Prix, $1.25 — franco, $1.35.

Compte rendu par Suzanne Giroux, Visiteuse officielle des Ecoles d'Infirmières, l'Association des Infirmières de la Province de Québec.

C'est un livre agréable! Voilà l'impression que m'a donnée la lecture de ce livre. Les



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infirmières peuvent le conseiller à leurs malades, lecture intéressante à faire durant une convalescence. Le Dr. Séguin écrit dans un style très personnel, d'un ton juste. Il émaille d'anecdotes amusantes, de réflexions badines l'enseignement sérieux qu'il donne à son lecteur.

Le Dr. Séguin a su donner aux profanes, si avide de connaître la science médicale, à la fois des renseignements susceptibles de satisfaire leur curiosité, et des conseils qui leur aideront à marcher d'un pas plus allègre et avec plus d'assurance dans le chemin de la vie.

Alberta

The following are recent staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Eleanor Jamieson* (University Hospital, Edmonton, and B.Sc. in public health nursing, University of Alberta), Athabasca health unit, Colinton; *Patricia Newell* (University Hospital, Edmonton, and U. of A. public health course), Brooks health unit; *Muriel Sweetnam* (University Hospital, Edmonton, and U. of A. public health course) as relief nurse at Youngstown.

Transfer: *Ethel Jones*, district nurse at Vauxhall, to Drumheller to be in charge of child welfare centre.

Leaves of Absence: *Jeannette McInnis* and *Marguerite Fitzsimmons*. *Wilma McCordick*, after a sojourn in the British Isles, has returned to Rocky Mountain health unit.

Resignation: *Dorothy Myers* from Pembina health unit at Westlock.

Canadian Red Cross

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia: APPOINTMENTS — *H. O. Mann* (Memorial Hospital, St. Thomas) as matron and *Mary E. Harris* (St. Joseph's Hospital, Hamilton), McBride outpost; *Sophia Smith* (Misericordia Hospital, Winnipeg), Cecil Lake; *Lynne M. Hamlin* (Wellesley Hospital, Toronto), Greenwood; *Norma A. York* (Royal Alexandra Hospital, Edmonton), Lillooet; *Margaret C. Ross* (Nanaimo Hos-

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Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

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pital), matron, *Mrs. Florence B. Sikler* (Regina General Hospital), *Mrs. Luella C. Brooks* (Prince Rupert General Hospital), *Mary F. Piper* (St. Bartholomew's Hospital, London, Eng.) and *Iris Siddells* (Wellington Public Hospital, New Zealand), to newly-opened hospital at Terrace. RESIGNATIONS — *Isobel Whitaker, Amy C. McGavin,* and *K. S. McKim* from McBride; *Mary E. Malloy* from Cecil Lake; *Mrs. F. E. Robinson* from Greenwood to be married; *A. J. Richardson,* to return to England, from Bamfield. LEAVE OF ABSENCE — *Eleanor M. Coulter* from Bamfield for post-graduate work.

New Brunswick: APPOINTMENTS — *Marion Palmeter* (Ottawa Civic Hospital), Tobique Valley; *Mrs. Ruth Williams* (Fisher Memorial Hospital), Harvey Community Hospital. RESIGNATIONS — *Alice Farquhar* from Tobique Hospital; *Marjory Bennett* from Harvey Community Hospital; *Harriett Hughes* from Kingston Hall Community Hospital; *Ethel Guptill* from Grand Manan outpost hospital.

Quebec: APPOINTMENT — *J. Lillian Liddle* (Sherbrooke Hospital), Barachois, Gaspé South nursing station.

M.L.I.C. Nursing Service

Helene Beaudet (Hotel Dieu, Montreal, and University of Montreal public health course), a member of the Montreal staff for several years, has retired from active duty as a Metropolitan nurse. *Catherine Lamarre* (Hôpital de l'Enfant Jésus, Québec) and *Cécile Leclerc* (St-Jean de Dieu, Gamelin, Que.), who have completed the public health course at the University of Montreal, have resumed duties at Montreal.

Appointments: *Madeleine Bélanger* (Hotel Dieu, Montreal, and U. of M. public health course) and *Marie-Claire Mathieu* (Notre-Dame, Montreal, and U. of M. public health course) to Montreal.

Transfers: *Claire Bernier* (Hotel Dieu, Montreal) from Montreal to Jonquière, Que.; *Gertrude Gouin* (Notre-Dame, Montreal, and U. of M. public health course) from Montreal to St. Hyacinthe, Que.; *Marianne Laframboise* (Sacred Heart, Cartierville, Que. and U. of M. public health course) from Jonquière to Chicoutimi, Que.; *Gertrude Lapointe* (St. Vincent de Paul, Sherbrooke, and U. of M. public health course) from St. Hyacinthe to Chicoutimi.

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Resignation: *Pauline de Villers* (Notre-Dame, Montreal, and U. of M. public health course), of the Quebec City staff, to be married.

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Margaret MacLachlan* (Bachelor of Science in Nursing, University of Toronto School of Nursing) as director, public health nursing, newly-organized Simcoe County health unit. Appointed to staff: *Dorothy Ball* (Victoria Hospital, London; University of Western Ontario certificate course; McGill University course in administration and supervision) and *Jewel Killorin* (Grey Nuns' Hospital, Regina; certificate and advanced courses in administration and supervision, U. of T.) as supervisors; *Charlotte Benson* (Hospital for Sick Children and U. of T. certificate course); *Glenna Downey* (Royal Victoria Hospital, Barrie, and U. of T. certificate course); *Mrs. Ruth Wilson* (St. Andrew's Hospital, Midland, and U. of T. certificate course); *Eileen Kirton* (Toronto General Hospital and McGill certificate course); *Margaret Marshall* (T.G.H. and McGill degree course); *Dorothy Morrison* (Hospital for Sick Children and McGill certificate course); *Ruth Roszell* (T.G.H. and U. of T. certificate course); *Dora Purdon* (Ross Memorial Hospital, Lindsay, and U. of T. certificate course), formerly staff nurse with Leeds and Grenville health unit; *Mildred Small* (Victoria Hospital, London, and U. of W.O. certificate course).

Marion Thompson (T.G.H. and U. of T. certificate course and lecture course in administration and supervision in public health nursing) as supervisor of public health nursing with newly-established health unit in Wellington County; *Helen Etherington* (St. Catharines General Hospital and U. of T. certificate and advanced courses in administration and supervision), formerly supervisor, public health nursing, with Welland and district health unit, to newly-formed health unit of Kenora-Keewatin area in capacity of supervisor of public health nursing.

Mary Dunsmore (Toronto Western Hospital and U. of T. certificate course), Waterloo Township board of health; *Erna Penner* (Women's College Hospital, Toronto, and U. of T. certificate course), York Township board of health; *Nora Cumberland* to Etobicoke Township board of health after obtaining Bachelor of Science in Nursing degree at U. of T.

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Supervisor of Nursing, Ontario Hospitals, Department of Health, Parliament Bldgs., Toronto 2.

Resignations: *Florence Greenaway* (T. W.H. and U. of T. certificate course and McGill course in administration and supervision in public health nursing) as supervisor, public health nursing, Bruce County health unit, to pursue post-graduate study, and *Mary McLaughlin* (U. of T. degree course) from unit; *Mrs. Margaret (Roberts) Hartwick* (T.G.H. and U. of T. certificate course) from Huron County school health service; *Elinor Hall* (Royal Victoria Hospital and U. of T. certificate course) and *Alice Macklin* (Victoria Hospital, London, and U. of W.O. certificate course) from Elgin-St. Thomas health unit; *Pearl Sewell* (Owen Sound General and Marine Hospital and U. of T. certificate course) from Lennox and Addington health unit; *Frances Simpson* (Royal Victoria Hospital, Montreal, and U. of T. certificate course) from Dufferin County health unit; *Mrs. Hilda Roy* (Hamilton General Hospital and U. of W.O. certificate course) from Brant County health unit; *Burma Morlock* (St. Joseph's Hospital, London, and U. of W.O. certificate course) from Northumberland and Durham health unit; *Marjorie MacEwen* (Ottawa Civic Hospital and U. of T. certificate course) from Ottawa Board of Education.

News Notes

NEW BRUNSWICK

MONCTON:

Mrs. Roberta Perry, president of the Moncton Chapter, was in the chair at a recent meeting. The guest speaker was Dr. R. D. Landry, district medical health officer, whose talk on "Public Health in New Brunswick" traced its history from 1600 to the present time. It was decided to give a copy of "Three Centuries of Canadian Nursing" to the members of the graduation class of the Moncton and Hotel-Dieu Hospitals having the highest standing in nursing. Food boxes are being sent to a British nurse. Tickets will be sold for a set of matched travelling bags.

Twenty-one graduates received their diplomas at the exercises of the school of nursing of Moncton Hospital. Miss Tait was the valedictorian. The Hon. G. H. Blakney, Minister of Education for New Brunswick, was the guest speaker. A bursary, donated by Fort Moncton Chapter, I.O.D.E., was won by M. Murray. After the ceremonies a reception was held for the class and their guests by the board of directors.

The class of 1948 was also entertained at a banquet and dance, given by the Nurses Hospital Aid, when ninety members were present. The toast to the new graduates was given by Barbara Beattie, superintendent of nurses, and responded to by Doris Jones. During the dinner, Mr. G. B. Macauley supplied the music. Hazel Little sang several selections, accompanied by Freda LeBlanc at the piano.

SAINT JOHN:

General Hospital:

At the graduation exercises of the Saint John General Hospital School for Nurses, Dr. Hayes was the special speaker. "You are graduates of the one of the oldest schools of nursing in Canada," Dr. Hayes said, "and are heirs to its glorious traditions." He reviewed the earlier years of the training school when students were required to take only two years' training, with part of it completed

in the homes of patients. The invocation and Nightingale Pledge were given by Rev. A. J. Langley and the presentation of diplomas made by Dr. D. C. Malcolm, a member of the board of commissioners of the hospital. The pins were presented by Margaret Murdoch, superintendent of nurses.

Flora E. Elsey was valedictorian. Three prizes were won by Iris Cooper, while Isabell Huestis and Miriam Allen were double winners. Miss Cooper was awarded the Saint John Medical prize for highest standing for three years, presented by Dr. George White, president of the society; the Dr. Walter White prize for highest standing in surgical nursing, presented by Ralph Gale, hospital superintendent, and was joint winner of the general proficiency prize with Miss Allen. Miss Allen was also winner of the Women's Hospital Aid prize for highest standing in obstetrical nursing (junior division), presented by Mrs. E. R. Hagerman, president of the Aid. Mrs. Hagerman also presented a similar prize in the senior division to Miss Huestis, who was also winner of the hospital alumnae prize for highest standing in the three years (senior division). This prize was presented by B. Selfridge, alumnae president.

The board of commissioners of the hospital gave a reception following the exercises when the guests were received by Dr. Malcolm, Mr. and Mrs. Gale, and Miss Murdoch. Presiding over the coffee urns were Mmes Malcolm, G. B. Peat, N. Skinner, and J. H. Vaughan, assisted by members of the nursing staff.

The alumnae association entertained in honor of the 1948 class at a dinner-dance and bridge, when B. Selfridge, the president, was in the chair. Her address of welcome was responded to by Mary Barnes. Nerea Foster, of the 1948 class, and Jean Porter were soloists. Marjorie Clarke lead with the singing of songs especially composed for the graduating class.

The nursing staff of the General Hospital recently entertained at tea in honor of Marion Myers, instructor, who has resigned to accept the position of lady superintendent at Saint John Tuberculosis Hospital. On behalf of the staff, Miss Murdoch presented her with a piece of Diechmann pottery. Lyla Belding presided over the tea table, assisted by Misses Chisholm, Searle, Saunders, Huestis, McLaren, and Hanscome.

Miss Huestis, a new graduate, has joined the obstetrical department.

Provincial Hospital:

On the eve of her departure for Montreal, Pauline Vail, who has been on the staff for the past four years, was presented with a travelling bag by her associates. Grace Murray is a new addition to the staff.

St. Joseph's Hospital:

The history of nursing through the ages to its present high professional status was outlined to the 1948 graduating class of the school of nursing of St. Joseph's Hospital by Dr. F. D. Wanamaker at the recent graduation ceremonies. Dr. T. E. Grant was chair-

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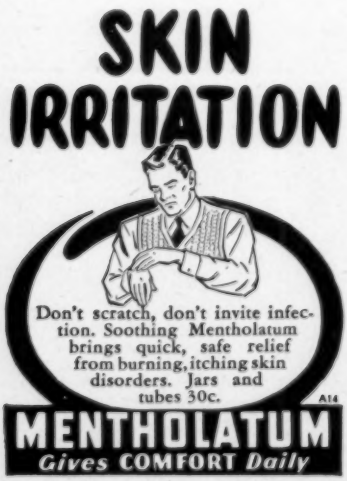
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man, while Mayor James D. McKenna extended the best wishes of the city and welcomed the visiting parents. In his talk to the new class, Dr. Wanamaker recalled that St. Joseph's graduated its first class of nurses in 1918 and since then more than three hundred nurses have gone from the school to take their places in the profession.

Mary Clara Rogers was the grand prize winner, receiving five of the seven awards, including those for highest standing in theory for three years, in Christian doctrine, in medical ethics, in surgical and obstetrical nursing. Mary M. Campbell received the first prize for efficiency in bedside nursing and Mary E. Morey was second prize winner in that field. The awards were presented by Dr. G. M. White, president, Saint John Medical Society, Rev. J. A. Gilbert, hospital chaplain, Msgr. Cronin, and Mrs. McLaughlin, hospital alumnae president.

Mrs. J. McLaughlin, president of the alumnae association, presided at the dinner dance held in honor of the class of 1948. B. Wallace and C. McAloon were in charge of arrangements. The toast-mistress was Rosemary McAuliffe while Mona McDermott rendered two solos during dinner.

ONTARIO

District 1

CHATHAM:

The alumnae association of the Public General Hospital were joint hostesses with St. Joseph's Hospital at the recent District 1 meeting. Miss Edith McDowell, Dean of the School of Nursing, University of Western Ontario, and Mr. A. Sparks, field secretary of the Canadian Institute for the Blind, were guest speakers at the well-attended session.

Miss M. Barrett of Sussex, England, a retired nurse, has received seven boxes of food, clothing, and magazines, during the past eight months, and letters of appreciation have been forwarded to the alumnae. Rev. and Mrs. J. W. Felix of Guernsey Island have also been "adopted" by the members and five boxes have been sent to them.

District 5

OSHAWA:

Dr. Victoria Cheung, superintendent of Kongmoon Hospital in South China, spoke to the members of District 5 at a recent meeting. Dr. Cheung told of conditions in that hospital which is sponsored by the United Church of Canada. She also spoke of the five "family" relationships which exist in China— the relationship between emperor and subjects, parent and child, husband and wife, older brother and younger brother, and between friend and friend. The Chinese people do not envy Canadians what they have, only what they waste, Dr. Cheung said. The speaker, who is a University of Toronto graduate, was introduced by Thelma Green of the Department of Health, Toronto. Dr. Cheung was thanked by Mrs. A. E. Owen who at one time, with the late Rev. Owen, was a missionary nurse in China and who has been made a

life member of the Nurses' Association of China. Prior to Dr. Cheung's talk, dinner was served to over one hundred members.

Mary Millman, convener, Legislation Committee, R.N.A.O., spoke at the afternoon session on "The Next Step in the Practice Act." The Ontario Nurses' Act asks that licence to practise in Ontario be granted both to registered and practical nurses. Miss Millman urged members to stand behind the Act and publicize it as much as possible. A panel report of the R.N.A.O. annual meeting was prepared by the first vice-president and section conveners and presented by Elizabeth Bregg and Audrey Prendergast. Jessie Wallace, chairman, presided at both sessions.

District 7

BROCKVILLE:

Helen Corbett was in the chair at a recent meeting of District 7, held at the Ontario Hospital, when forty-five members were present. Reports of the various committees were read and approved. It was moved by Miss Acton, Kingston, and seconded by Miss Purcell, Brockville, that a notice regarding the bursary to be awarded by the district be printed in local newspapers to acquaint the public in this respect. The bursary is to go to a high school student who wishes to enter nursing. Rita Moyle, Smiths Falls, reviewed the annual R.N.A.O. convention.

A committee was formed to contact all members of Parliament, elected on June 7 within the district, with regard to the presentation in Parliament of the proposed Ontario Nurses' Act.

Mr. J. R. Radford, owner and manager of radio station CFJM, Brockville, was the guest speaker, introduced by Miss Corbett. His extremely interesting talk revealed the inside picture in the preparation of radio programs and his pointers on how to speak while "on the air" were very helpful.

Ontario Hospital:

At the end of March, seventy-five graduates of Ontario Hospital School for Nurses met for the purpose of forming an alumnae association. Nurses were present from many far distant points and from classes from 1919 to the present time.

In May, Dr. Harold Frank, of the hospital staff, addressed the members, choosing as his topic, "Mental Health and Ill Health." June 21 saw the first annual reunion in the form of a banquet when more than a hundred graduates enjoyed the repast and the social hour which followed. Representing the class of 1915 were Mrs. Alma Broad, Brockville, and Mrs. Ida Perrin, Smiths Falls.

District 8

Cornwall General Hospital:

The graduation exercises were held in the high school auditorium on June 8. S. E. Fennell, K. C., chairman of the Board of Governors, welcomed the large audience who

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By Ella L. Rothweiler and Jean Martin White. A leading American book for schools of nursing, now in its twelfth printing. This latest edition contains material on blood and plasma banks and on the iron lung. With activities and questions for each chapter. 144 illustrations. 793 pages. Twelfth printing. 1946. $4.00.

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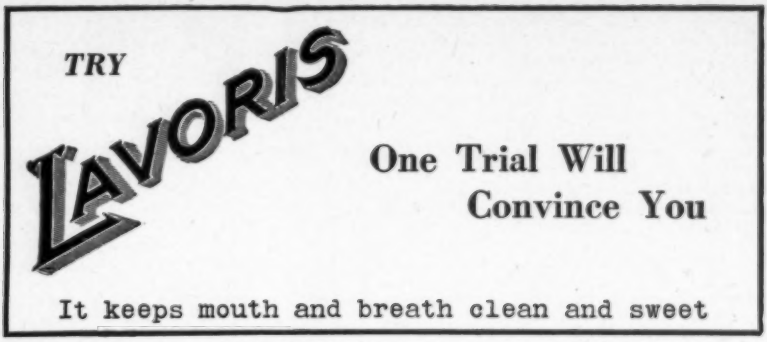

had come to pay tribute to the graduating class. Dr. A. E. R. MacPhee, on behalf of the Medical Society, expressed his confidence that these new graduates would assist in filling the urgent need for expert and efficient nursing personnel. Solos were rendered by Bernadette Legris, R.N., and R. R. Heard, accompanied by Kathleen Wyatt. Margaret E. Kerr gave the graduation address, taking as her topic "What Do You Expect from Life?" The valedictory address was given by Velma Daye. Diplomas and pins were presented by Mr. Fennell, Miss Martha Nephew, superintendent, and Evelyn Paul, instructor of nurses. Melba Carruthers was winner of the general proficiency scholarship and Mavis Beckstead of the obstetrical scholarship.

A reception was held at the Colquhoun Memorial Nurses' Residence where the members of the class received congratulations of their relatives and friends. From a beautifully appointed table, Mmes L. D. Gallinger, F. B. Brownridge, A. H. Parker, and J. C. Wilson poured tea and coffee, assisted by the staff.

District 10

FORT WILLIAM:

McKellar Hospital:

The members of this alumnae association are kept busy by their various activities. Articles of good used clothing and food-stuffs are brought to the monthly meeting by each member to be made up into parcels for the nurses overseas. A drive for funds was held in the fall, each member donating a dollar instead of holding the regular fall tea. A Christmas news bulletin was sent out to all paid-up members. This project was convened by Mrs. McConnell, assisted by Misses Ballantyne, Hogarth, and Mrs. Payette. A successful tea was held in March, convened by Mmes Wallace and Higginbottom. About one hundred nurses attended the Vesper Service held at St. Paul's Anglican Church in May.

The 1948 graduates were entertained at dinner by the alumnae when the graduates were presented with an electric mantel clock for the reception room, suitably engraved.

The alumnae has a scholarship fund for paid-up members only. It is a two hundred dollar interest-free loan, repayable two years after the course is finished.

QUEBEC

MONTREAL:

McGill School for Graduate Nurses:

Hilda Bartsch, who resigned as superintendent of nurses at Victoria Public Hospital, Fredericton, N.B., has gone to Moncton as superintendent of the T.B. unit at the D.V.A. Hospital. Elaine Corbett is director of nursing service with the Red Cross in Montreal. Mrs. Grace Curtis (TS '46) is superintendent of nurses at Colchester Co. Hospital, Truro, N.S. Helen Hewton (PHN '25-26) is director of nursing at the Reddy Memorial Hospital, Montreal, replacing Dorothy MacRae (Admin. '46) who resigned to be married. Agnes Tennant (TS '37-38 and McGill School for Social Work '47) is serving as director, Social Service Department, Montreal General Hospital. Mavis Thompson (TS '47) is superintendent of the D.V.A. Hospital, Nanaimo, B.C. The superintendent of nurses at Royal Edward Laurentian Hospital, Ste. Agathe, Que., is Louise Bartsch (B.N. in Admin.).

Margaret Conlogue (PHN '39-40) is with the V.O.N. in Woodstock, N.B. Ann Bernice Connor (TS, B.N. '46) is on the teaching staff at the Kingston General Hospital, Ont. Barbara Convery (TS '46) is orthopedic instructor at Maine General Hospital, Portland. Jeannine Coupal (PHN '38-39) is with the B.C. Provincial Department of Health. Rita Doyon (PHN '42-43) is on the staff of the Montreal health department. Edna Felsing (TS '42-43) has returned to Jeffery Hale's Hospital, Quebec. Gertrude Gorelick (TS '46) is clinical supervisor, St. Mary's Hospital, Montreal. Edith Green (TS '46) is director, teaching department, Royal Jubilee Hospital, Victoria, B.C. Eleanor Martin (TS '41) is instructor at the Metropolitan School of Nursing, Windsor, Ont. Martha Racey (T '28-29) has gone to the staff of the Stratford General Hospital from Plummer Memorial Hospital, Sault Ste. Marie, Ont. Phyllis Walker (Admin. '46) is nurse-in-charge at the outpatient department, Montreal General Hospital. Katherine Weatherhead (TS '41) is supervisor of central office and educational director of V.O.N., Montreal. Jean Thirlaway (B.N. in TS '47) is on the staff of the Children's Memorial Hospital, Montreal. Win Burwash (PHN '47) and Louella Downing

(TS '47) are with the Child Welfare Association of Montreal.

Madeleine Flander (TS '31-32) has been taking advanced work in pediatrics in Boston. Dorothy Dick (PHN '41-42) has been taking supervision in public health at Columbia University. Edith Mewhart (TS '42-43) has been studing psychiatry at the State Hospital, New York. Ann Peverley (PHN '34-35) has been attending Columbia University, working for her B.S. degree. Alice Major (B.N. in TS '47) is taking her M.A. at Columbia University.

The following 1947 graduates are with the V.O.N.: *B.N. in public health* — Ruth Austin, Cornwall; Bea Seeds, Vancouver; Joy Clarke, Moncton. *Certificate* — Joan Salon, Northern Ontario; Vivian Sharpe, Nova Scotia; M. Manless, Ontario; Kirsten Nelson, North Vancouver; Catharine Murray, Halifax.

The following are with the provincial departments of health: *Alta.*— June Palley; *B.C.*— Dorothy (Betty) Brown, Jean Coupal; *Man.*— Phyllis Hadland, Betty MacKay; *N.S.*— Jean Ellis, Anna MacDonald, Joy MacDonald, Frances Setchell, Marjorie Tupper; *Ont.*— Dorothy Adams, Jeannette Gillespie; *Sask.*— I. Langstaff.

SASKATCHEWAN

Humboldt:

The graduation breakfast for the new class of St. Elizabeth's Hospital was held at the home of Mrs. Jenkins where they were entertained by the chapter members of this district. The graduates were presented with a motto "The Nightingale Pledge" by the alumnae and chapter members.

Mildred Lindrose, as representative of the student body, attended the S.R.N.A. convention held in Saskatoon.

Qu'Appelle Valley:

Blanche Arkinson, the chapter president, attended the S.R.N.A. convention as chapter delegate. Mrs. Dora Fisher, who has returned from England, is back on the Fort San staff. Mrs. M. Miller and June Macphail have also joined the staff. Catherine Maddia has left the San staff to go to the Fort Qu'Appelle Indian Hospital. A weiner roast was held for Dorothy Stribbell who has left to be married.

Regina:

General Hospital:

The General Hospital nurses extend hearty welcome to the 1928 graduates who have recently celebrated their twentieth anniversary reunion.

I. Kovach and Mrs. L. (Seamer) Lewis have joined the staff. Resignations have been accepted from B. Cookson and W. Wilkins, the former to be married.

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THE ASSOCIATION OF NURSES of the PROVINCE OF QUEBEC

The 1948 Fall examinations for Provincial Registration will cover two groups of candidates and will be held as follows:

GROUP A: Graduates qualifying for the licence to practise will write in Montreal, Quebec, and Sherbrooke on **November 8, 9 and 10, 1948.** Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school.

GROUP B: Students who will have completed their first year before **October 1, 1948,** will enter the preliminary test covering oral, practical, and written, which will be held on **October 18, 19, 20 and 21, 1948.** (Time to be announced in each school.) Applications must be filed on or before **September 30, 1948.**

For application forms and all information relating to the examinations apply to the headquarters of the Association. *Applications for final examinations must be received by October 15, 1948.*

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Secretary-Registrar
506 Medical Arts Bldg.
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Positions Vacant

Supt. of Nurses & Nursing Service. Fully modern 45-bed hospital. Wing under construction to provide total of 80 beds. Salary: $195 per month with full maintenance in fully modern staff residence. Full staff of Registered Nurses working straight 8-hr. day with 1 day off each week. Apply, stating qualifications, enclosing references, Supt., Union Hospital, Canora, Sask.

Supt. of Nurses for Tranquille Unit, Division of Tuberculosis Control. 340-bed hospital in Southern Interior, 12 miles from Kamloops. Comfortable suite in nurses' home. Must be eligible for registration in British Columbia. *Qualifications:* Degree or diploma in Administration, Teaching & Supervision, or Public Health Nursing. 5 yrs' nursing experience, including at least 2 yrs. in executive position. Apply Director of Nursing, Division of Tuberculosis Control, 2647 Willow St., Vancouver, B.C.

Supervisor of Nursing for 110-bed General Hospital in Eastern Ontario with School of Nursing. Position requires experience & post-graduate course in Teaching & Supervision. Duties include assistance to Director of Nursing Service. Salary: $195 per month less maintenance provided at reasonable rates. Duties commence Sept. 1. Apply in care of Box 6, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Registered Nurse for Matron of 6-bed Municipal Hospital. No major surgery. Salary: $175 per month with full maintenance. 1 month vacation with pay after 12 months' service. Duties to commence as soon as possible. Apply Sec.-Treas., R.M. of Cut Knife, Sask.

Asst. Supt. of Nurses for 350-bed Tuberculosis Hospital. **Graduate Nurses for General Duty.** For particulars apply Miss C. L. Bartsch, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Operating-Room Supervisor immediately for 50-bed hospital. Full maintenance supplied & 1 month's vacation with pay after each yr's service. State qualifications, experience, salary expected. **Graduate Registered Nurses (2) for General Duty.** Full maintenance supplied. Apply Supt., Payzant Memorial Hospital, Windsor, N.S.

Asst. Night Supervisor for 140-bed hospital. Duties to commence middle of Aug. Apply, stating experience, expected salary, etc., Director of Nurses, Women's College Hospital, Toronto 5, Ont.

Delivery Room Nurses with special Obstetrical training or experience. Rotating shifts. Apply Director of Nurses, Women's College Hospital, Toronto 5, Ont.

Nursing Arts Instructor for School of Nursing connected with 100-bed hospital. Duties to commence immediately. Also **General Duty Nurses** at once. 6-day week. 8-hr. duty. Apply Supt. of Nurses, General Hospital, Woodstock, Ont.

Graduate Staff Nurses for modern 120-bed hospital, fully approved. 60 miles from New York City. Salary range: $2,100-$2,400. Vacation, sick time, 10 holidays. 48-hr. wk. Added compensation for evening & night duty. Salary increase every 6 months. Attractive residence facilities available if desired. Apply Director of Nursing, Horton Memorial Hospital, Middletown, New York.

Registered Nurses for small hospital — for General Duty, to assist in Operating-Room, Night Duty. Good salary. Apply Supt., Rosamond Memorial Hospital, Almonte, Ont.

General Duty Nurses. Salary: $125 per month with maintenance. Overtime paid. 8-hr. duty, 6-day wk. Apply Supt. of Nurses, Municipal Hospital, Brooks, Alta.

Graduate Nurses. Salary: $110 per month with time bonuses. $10 per month extra if living out. 8-hr. day, 6-day wk. 3 wks' holiday with pay. 2 wks' sick leave per annum. Full maintenance. Ideal living conditions. Fine nurses' residence. Apply Alexandra Marine & General Hospital, Goderich, Ont.

Registered Nurses for General Duty. 8-hr. day, 6-day wk. 4 wks' vacation with pay. 2 wks' sick leave with pay. Attractive residence. Apply, stating salary expected, Supt., Niagara Cottage Hospital, Niagara-on-the-Lake, Ont.

Graduate Nurses for completely modern West Coast hospital. All-graduate staff. Commencing salary: $150 per month less $25 for board, residence, laundry. Annual increment. 44-hr. wk. 1 month's vacation with pay after 1 yr's service. Transportation allowance not exceeding $60 refunded at end of 12 months. Apply, stating experience, Matron, General Hospital, Prince Rupert, B.C.

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By Open Competition — **REGISTERED NURSES**

(with Psychiatric training — required for the Provincial Mental Hospital (4000-bed) at Essondale, B.C.)

Salary: $174.00 rising to $202.00 per month including current Cost-of-Living Bonus. (Extra amounts paid for charge duty.)

Hours: 44 per week (5½-day week.)

Living accommodation available in Nurses' Residence. Maintenance—$20.00 per month. Positions permanent for single or self-supporting women under forty years of age who will be included in Superannuation plan. Candidates must be British Subjects, eligible for registration in the Province of British Columbia. (Preference given ex-servicewomen).

Application Forms obtainable from the **Civil Service Commission, Weiler Building, Victoria,** *or* **570 Seymour St., Vancouver,** *or* the **Business Manager, Essondale.** These should be completed and returned to the Chairman, Civil Service Commission, Victoria.

SURGICAL NURSES

There are two vacancies for Graduate Nurses who are interested in giving post-operative care to cases undergoing Thoracic Surgery at the Nova Scotia Sanatorium. Also a few openings for General Duty Nurses. Good living and working conditions.

Application forms may be obtained from the **Nova Scotia Civil Service Commission, P.O. Box 943, Halifax, N.S., or by telephoning No. 3-7341 — Branch 230.**

Supt. of Nurses with New Brunswick Registration for General Hospital with School for Nurses. Applications should give full details of education, post-graduate training, experience, references. Apply Restigouche & Bay Chaleur Soldiers' Memorial Hospital, Campbellton, N.B.

Supervisor for Clinical Teaching in 125-bed hospital. **Head Nurse** for 20-bed ward. 8-hr. day, 6-day wk. 1 month vacation with pay after a yr. Apply, stating qualifications, salary expected, to Supt. of Nurses, Children's Hospital, Winnipeg, Man.

Qualified Registered Nurse as Instructor. 150-bed hospital. Duties to commence Sept. Salary: $150 per month plus $30 maintenance. Apply, stating qualifications, experience, age, religion, to Supt. of Nurses, General Hospital, Chatham, Ont.

Qualified Instructors (2) for 100-bed hospital: **Nursing Arts Instructor & Science Instructor.** Duties to commence later part of Sept. Apply, giving full particulars as to qualifications, experience, salary expected, Supt. of Nurses, Sherbrooke Hospital, Sherbrooke, Que.

Operating-Room Nurses and General Staff Nurses. 44-hour wk. Starting salaries: $150. and $140 gross respectively. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Registered Nurses for Pediatric-Orthopedic Hospital. 8-hr. day, 6-day wk. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospitals for Crippled Children, Montreal Unit, Que.

Registered Nurses for General Staff at Tranquille Sanatorium, situated on Kamloops Lake near Kamloops, B.C. Gross salary for 8-hr. day, 5½-day wk.: $174 per month during 1st yr., $186 per month for 2nd yr. & $5.00 raise per month in 3rd, 4th, and 5th yrs. of service, minus $27.50 for board, room, laundry. 31 days' vacation per annum with pay plus 11 days statutory holidays. 14 days sick leave each yr. accumulative with pay plus 6 days incidental illness. Superannuation Plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Registered Floor Duty Nurses for small hospital in modern community. Salary: $145 with full maintenance. 8-hr. duty rotating. 6-day wk. 3 wks.' vacation with pay per yr. Sickness insurance. Retiring plan. Apply Boisvert Memorial Hospital, Baie Comeau, Que.

NURSES — WANTED

Required for **Roseway Hospital, Shelburne, N.S.—One Operating-Room Charge Nurse** and **an Assistant for Scrub Nurse.**

Application forms may be obtained from the

Nova Scotia Civil Service Commission, P.O. Box 943, Halifax, N.S.

or by telephoning

3 - 7341 - Br. 230.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock, and Toronto Psychiatric Hospital. Initial salary: $1,840 per annum, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 weeks' vacation, statutory holidays and special holidays with pay. 8-hr. day, 6-day wk. Apply to Supt. of Nurses at above hospitals.

Graduate, Registered Nurse for **Floor Duty.** Salary: $100 per month; full maintenance; increase of $5.00 per month after 1 year's service, up to 3 years. 8-hour duty. Blue Cross Hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

General Staff Nurses. 44-hour week. Gross salary: $155 plus laundry, with increases. Extra $5.00 all night rotation shifts. All perquisites. Registration in British Columbia essential. Apply to Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

General Duty Nurses for new 26-bed hospital. Salary: $120 per month with full maintenance. Increased $5.00 after 6 months. Straight 8-hr. 6-day wk. **Permanent Night Nurse.** 3 wks' holiday with pay after 1 year's service. Situated on C.P.R. line 50 miles north of Calgary. Excellent train & bus service. Apply Miss M. A. MacDonald, Matron, Municipal Hospital, Didsbury, Alta.

Registered Nurses (2) for General Duty. 44-hour week. Apply for further information to Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

Matron for 60-bed hospital with new wing to be added. Duties to commence immediately. State salary expected & qualifications. Also **Dietitian.** Excellent female cooks on staff. Duties also to include supervision of housekeeping staff, purchasing supplies, etc. Full maintenance if desired. State salary expected & experience. Apply J. M. Morrison, Asst. Sec., Municipal Hospital, Box 240, Red Deer, Alta.

Science Instructor for 322-bed hospital with Training School of 170 student nurses. Apply, stating age, training, experience, physical fitness, salary expected, furnishing references, to Medical Supt., General Hospital, Calgary, Alta.

Graduate Nurses for 40-bed General Hospital. Salary: $135 per month plus room & board. 8-hr. day. All modern conveniences. Plane fare paid from Edmonton. Apply Manager, Red Cross Hospital, Yellowknife, N.W.T.

Instructor & experienced **Operating-Room Nurse** for 188-bed hospital in Western Canada. Apply, stating in first letter experience, qualifications, to Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Public Health Nurse (fully qualified) to give full-time service in Municipality of Neebing. Salary: $2,000 per year with car allowance of 9 cts. per mile. Apply J. E. Crawford, Clerk, 206 Cuthbertson Block, Fort William, Ont.

Registered Graduate General Duty Nurses for Sept. 1. Gross salary: $155, less $35 maintenance, per month. Single rooms in nurses' home. Straight 8-hr. shift, change weekly. Apply, giving full particulars of training, references, etc., General Hospital, Ladysmith, B.C.

Assistant Residence Nurse by early Sept. for University of Toronto School of Nursing. Apply now to Secretary of School.